

CONFIDENTIAL

Medical Dental History Form For Patients Under Age 18

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ What sex was the patient assigned on their birth certificate? _____ Male Female

What is the patient's current gender identification? Male Female Other

What are the patient's preferred pronouns? _____

Social Security # _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*) Parent 1/Guardian Parent 2/Guardian Parent 3/Guardian Parent 4/Guardian

Other, if other, what is the relationship? _____

Parent 1/Guardian full name _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell phone (*if different*) _____ Home phone _____

Work phone _____

Parent 2/Guardian full name _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell phone (*if different*) _____ Home phone _____

Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____