Orthodontic Patient History Form

Personal Information

Full Name

Date of Birth

Gender

Phone Number

Address

Email

Dental/Medical History

Name of Physician

List any medical conditions

List any medications currently being taken

Have you had any surgeries?

Reason for orthodontic consultation

Allergies (including latex, medications, etc.)

Family Dental History

Is there a family history of orthodontic treatment?

If yes, please specify

Additional Information

Other relevant information