SCHIECK ORTHODONTICS

Patient Information (Under 18)

Date of Birth: _____ Date of Exam: _____

Patient's Name: _____ Age: _____ Sex: _____

Preferred Name: _____ Family we have treated: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Preferred method of contact (text, email, letter)? _____

School: _____ Grade: _____

Physician: _____ Dentist: _____

How did you hear about our office? (ex: referral, sign, friend): _____

Father's Name: _____ DOB: _____

Employer: _____ Occupation: _____

Work phone: _____ Email: _____

Mother's Name: _____ DOB: _____

Employer: _____ Occupation: _____

Work phone: _____ Email: _____

Person Responsible for Account: _____

Parents are: Married _____ Divorced _____ Separated _____ Foster _____

Patient Lives With: Both _____ Mother _____ Father _____ Other (specify) _____

Patient Accompanied to Exam By: _____ Relationship: _____

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