HUDSON
ORTHODONTICS FOR ALL AGES

CONFIDENTIAL **DATE**_____

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name:_____ **First Name:**_____ **Initial:**____

Birth Date:____/____/_____ **Age:**_____ **Sex: Male**_____ **Female**_____

What Concerns YOU About Your Child's Teeth?_____

What Concerns YOUR CHILD About His/Her Teeth?_____

Attends School At:_____**Grade:**_____**Musical Instruments Played:**_____

Sports and /or Hobbies:_____

No. of brothers and sisters:_____ **Ages:**_____

Other family members treated here:_____

Birth Father's Height _____**ft.**_____**in.** **Birth Mother's Height** _____**ft.**_____**in.**

Patient's current height___**ft.**_____**in.**___

Custodial Parent(s) or Guardian(s):_____

Ph. #(if different than patient)_____-_____

Address (if different than patient):_____

City:_____ **State:**_____**Zip:**_____

Name of Patient's DENTIST:_____**Phone No.:**_____

Dentist's Address:_____

City:_____**State:**_____**Zip:**_____

Date Last Seen:_____ **Reason:**_____

Name of Patient's PHYSICIAN(s):_____**Phone No:**_____

Physician's Address:_____

City:_____**State:**_____**Zip:**_____

Date Last Seen:_____**Reason**_____