Shah Orthodontics

Tarak V. Shah, D.D.S.

Patient Information (MINOR)

Patient's Name _____/_____
First Middle Last Nickname

Birthdate _____ Age_____ Gender M___ F___

Street Address _____

City _____ State_____ Zip Code_____

Primary Phone Numbers (_____) _____ (Cell) (____) _____(Home)

Attends school at _____

Hobbies/Interests _____

Number of siblings _____ Names/ages _____

Whom may we thank for referring you? _____

Parental Information ____Single ____Married ____Partnership ____Separated ____Divorced ____Widowed

Parent/Guardian Name _____
Relationship to Patient _____
Date of Birth _____
Street Address _____
City _____ State ____ Zip _____
Cell Phone (_____) _____
Work Phone (_____) _____
Employer _____
Occupation _____
Email _____

Parent/Guardian Name _____
Relationship to Patient _____
Date of Birth _____
Street Address _____
City _____ State _____ Zip _____
Cell Phone (_____) _____
Work Phone (_____) _____
Employer _____
Occupation _____
Email _____

Responsible Party: _____

General Dentist: _____ Phone (_____) _____

Primary Physician: _____ Phone (_____) _____

Chiropractor: _____ Phone (_____) _____

Purpose of your visit/main concern/long-term dental goals

_____
_____
_____

Is there anything else you would like us to know about your child?

_____
_____
_____