CDF FAMILY ORTHODONTICS
Let Your Smile Shine

Patient Information Form (Adult)

Patient Name		DOB		Age	
Occupation					
Help us get to know you better!!					

What concerns do you have about your smile/bite	
What concerns have YOUR DENTIST mentioned about your smile/bite?	
Have you ever had orthodontic treatment before? If yes, when and where?	
Do you have any health/psychological/physical conditions we should be aware of?	
Do you have any oral habits we should know about? (Thumb or finger sucking, tongue thrust etc)	
Any apprehension about dental care?	
Who can we thank for sending you to our practice?	
We have been in the community for over 40 years, have we ever treated a member of your family? (Dr. Forwood started the practice in 1980)	
Other information you feel would help us treat you best?	

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