Milestone Kids Dentistry

Please submit your patient information by completing this form. Call us if we can be of any assistance.

Referred By*

- ◯ Doctor
- ◯ Patient

Referred By/Name*

Patient Name*

First Name

Last Name

Patient's Birth Date*

Month

Day

Year

Patient's Phone*

(000) 000-0000

Please enter a valid phone number.

Patient's Email*

example@example.com

Parent/Guardian Name*

Message or Main Concern

Type here...

Clinical Findings

- ☐ Class II
- ☐ Class III
- ☐ Missing Teeth
- ☐ Crossbite
- ☐ Overjet
- ☐ Crowding
- ☐ Pre-prosthodontics
- ☐ Deep Bite
- ☐ Spacing
- ☐ Impacted Teeth
- ☐ TMD

Preferred Contact Time*

Please select

Has Pano Been Taken?*

Please select

Does Any Treatment Need To Be Completed?*

Please select

If Yes To Above, What Treatment Needs To Be Completed?