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?**