Snyder Family Dentistry, LLC

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In order for us to serve you better, please complete the following prior to appointment:

Patients Name: Birthdate: Age: Weight: Sex:(M/F)

Name child prefers to be called: Social Security:

Address: Home Phone:
Street City State Zip

Father's Name: Mother's Name:

Address: Address:

Social Security # Social Security #

Birthdate: Birthdate:

Employer: Employer:

Present Position: Present Position:

Business Phone: Business Phone:

Parents Marital Status: Who will be responsible for this account?

Nearest Relative: Personal Reference:

Address: Address:

Phone: Phone:

Physician: Name of school child attends:

Referred By:

To help us in our treatment; please answer the following questions: (Mark X)

Is this the patient's first visit to a dentist? Yes ( ) No ( )

If not, how long since last dental visit?

Was all dental Work completed then Yes ( ) No ( )

Is-the patient worried or frightened today?

If there was previous dental experience:

Was it satisfactory? Yes ( ) No ( )

Was sedation or general anesthesia used? Yes ( ) No ( )

Were x-rays taken? Yes ( ) No ( )

Do you have fluoride in your drinking water at home? Yes ( ) No ( )

Do you have fluoride tablets or drops? Yes( ) No ( )

How many children in your family?_____

On these questions, mark (x) in the box if the answer is "Yes", leave blank if "No"

Is there sensitivity in the mouth to:

( ) Heat ( ) Cold ( ) Sweets ( ) Chewing ( ) Cold ( ) Biting ( ) Previous injury

Does the patient have a history of?

( ) Thumb sucking ( ) Mouth breathing

Has the patient had?

( ) A recent physical exam

( ) Any heart problems

( ) Any kidney problems

( ) Pain in region of ears

( ) Bleeding gums

( ) Any lung problems

( ) Any bleeding problems

( ) Allergy to local anesthetics

( ) Rheumatic Fever

( ) Tuberculosis

( ) Allergy to antibiotics _____

( ) Any other **ALLERGIES**

Cause of allergy _____

( ) Cerebral Palsy

( ) Epilepsy

( ) Diabetes

( ) Hepatitis

( ) Immune system disorders

( ) Scarlet Fever

Does the patient take any medication(s)? Yes/No

Name of medication(s) _____

Please tell us about a highlight in your child's life recently. New brother, sister, pet, accomplishment, etc.

_____

_____

Here's your space. Please tell us anything else you are concerned about. Things we should know, but so far haven't asked.

_____

_____

_____

Signature: _____ Date: _____