Snyder Family Dentistry, LLC

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

Name: Home phone: Cell phone:

Address:
Street City State Zip

Birthdate: Age: Social Security

Marital Status: Single Married Divorced Separated Widowed

Firm Employed by: Work phone:

If Student Where:

Name of Spouse/Guardian: Social Security:

Firm Employed by Work phone:

Who is responsible for this account? Phone

Dental History:

Reason for scheduling appointment:

Previous Dentist name: Phone number: City/State:

Date of last dental visit? When was your last cleaning?

History of gum surgery? If yes, why?

Any complications with last dental treatment?

Are you nervous about dental treatment? If yes, why?

Have you ever been pre-medicated with antibiotics for dental treatment? Yes/No.

Medication and dosage: How often do you brush?

Do your gums bleed? Yes/No Do you have sensitive teeth?

Any other dental trauma, problems or concerns, please list here:

Health History

It is important that we know about your medical history. Many have a direct bearing on your dental health. We will review the questionnaire -and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's Name _____ Date of Last Physical Exam _____

Do you have or have you had any of the following?

ANY heart problems	yes no	Allergies to anesthetics	yes no
High blood pressure	yes no	Allergies to medicines	yes no
Low blood pressure	yes no	Allergies to:	
Circulatory problems	yes no	Anemia	yes no
Nervous problems	yes no	Arthritis	yes no
Radiation treatments	yes no	Asthma	yes no
Excessive bleeding	yes no	Diabetes	yes no
Stroke	yes no	Hepatitis	
Typhoid Fever	yes no	Malignancies	yes no
Tonsillitis	yes no	Measles	yes no
Tuberculosis	yes no	Mumps	yes no
Ulcers	yes no	Rheumatic Fever-	yes no
Sinus Problems	yes no	Scarlet Fever	yes no
Pregnant	yes no	Immune Systems Disorders	yes no

Are you currently of have you ever been treated with **bisphosphonate drugs**? Yes/No
If yes, please list medication, dosage and when:

Please describe any current medical treatment, impending operations or any other medical or dental information that may possibly affect your dental treatment. Also, include any questions or concerns you may have regarding your dental health below:

Signature: _____ Date: _____