Family Dentistry
Annette Skowronski, DDS, FAGD, PC

Lip Class: ______
Tongue Class: ______

Patient Information

Name____ Date____________

Address__________________________ City____________ State______ Zip ________

Date of Birth ___/___/___/ Gender M____ F____ Email ____________________________

Home Phone (___)__________ Cell Phone (___)__________ Work Phone (___)__________

Do you prefer to receive calls at: Home_____ Cell_____ Work_____

Parent names (both mother and father): ____

Contact phone number if different from patient: (___)______________

Whom may we thank for referring you to our practice? ________________________

Reason for today's visit: ____

Currently Breastfeeding? ___Yes ___No

Currently Bottle feeding? ___Yes ___No

If answered yes for the above 2 questions please explain any problems with breastfeeding and/or bottle feeding: ____

If not Breastfeeding or bottle feeding at what age did you stop? ____________________

Are you under any medical treatment? ___Yes ___No Prior Surgery? ___Y ___N

If yes, please explain: ____

Bedwetting: __Yes __No

Snoring: __Yes __No

Daytime Sleepiness: __Yes __No

Please list all medications or supplements taken: ______________________________

Known Allergies: ____

Pediatrician's Name: __________________________ Phone: (___)______________

I acknowledge that I have received the "Notice of Privacy Practices" from the office of Dr. Skowronski.

Signature: ________________________________ **Date:** ______________