Patient Registration

Date _____

Personal Information

Name _____ Nickname _____

School _____ Grade _____ ☐ Male ☐ Female

Age _____ Date of Birth _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Father's Name _____ Employer _____

Business Phone _____ Cell Phone _____

Mother's Name _____ Employer _____

Business Phone _____ Cell Phone _____

Family Dentist _____

Child's Interests _____

Favorite Person _____ Favorite Fictional Character _____

Siblings _____

Insurance Information

Person financially responsible _____ _____
(relationship to child)

Address (if different from above) _____

Social Security _____ Date of Birth _____

Dental Insurance Company _____ Policy Number _____

Whom may we thank for referring you?

_____

a lifetime of beautiful smiles
Therese M Bonamer
Board Certified Pediatric Dentistry DDS, Inc.

Patient Name _____

Dental and Health History

Date of last visit to dentist _____ For what service? _____

At what age did your child's first tooth erupt? _____

Please check all that apply to your child

☐ Dental problems? If so, please comment _____

☐ Unhappy dental experiences? If so, please comment _____

☐ Sleep with a bottle? If so, what did the bottle contain? _____

What age was bottle feeding stopped? _____

☐ Use a sippy cup? If so, what did the cup contain? _____

☐ Was your child breast fed? If so, until what age? _____

☐ Speech difficulties? If so, please comment _____

☐ Does your child brush his (her) own teeth? If so, when _____ If not, by whom _____

☐ Is dental floss used? How often? _____ ☐ Is water fluoridated? If not, any fluoride medication used? _____

☐ Has your child ever had any injuries to mouth-teeth-head? If so, please comment _____

☐ Do you have any reservations to necessary diagnostic dental x –rays?

Child's attitude about coming today _____

Oral Habits

☐ Thumb sucking
☐ Finger sucking
☐ Nail biting
☐ Mouth breathing
☐ Pacifier
☐ Lip sucking
☐ Grinding of teeth

Medical History

Child's Physician _____

Address _____

Phone _____

Date of last physical exam _____

Any concerns _____

Has your child:

☐ Presently under the care of physician?

☐ Currently taking any medications?
If so, what? _____

☐ Ever been hospitalized?
If so, for what reason _____

☐ Ever had an operation?

☐ Have any known drug allergy
If so, please name _____

☐ Have any known food or other allergy?
If so, please name _____

☐ Immunizations up to date?
List tetanus shot or booster _____

Is there any family history of:

☐ Bleeding disorder ☐ Diabetes ☐ Heart disease

☐ Hepatitus ☐ HIV

Please check all that apply

☐ Anemia
☐ Asthma
☐ Birth defects
☐ Bleeding disorder
☐ Breathing difficulty
☐ Broken bones
☐ Cerebral palsy
☐ Chicken pox
☐ Cleft lip or palate
☐ Convulsions/Seizures
☐ Diabetes
☐ Emotional problems
☐ Epilepsy
☐ Fainting or dizziness
☐ Hearing problems
☐ Heart defect/murmur
☐ Hepatitis/Liver disorder
☐ Kidney disease
☐ Lung disease
☐ Mastoid infection
☐ Measles
☐ Mental retardation
☐ Mononucleosis
☐ Mumps
☐ Nervous condition
☐ Neurological disorder
☐ Rheumatic fever
☐ Thyroid disorder
☐ Vision problems

☐ Other _____

Additional information/patient update

Parent's Signature _____ Date_____