

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?

Oral Habits

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

Child's attitude about coming today _____

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
- Hepatitis 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 disorder
- Hepatitis/Liver
- 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 _____