Dr. Robert A. Bond and Dr. Renee M. Sellers
Welcome To Our Practice!

☐ Male ☐ Female

Child's First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number (optional) ____ Date of Birth ____ Home Phone ____ Daytime Phone ____

Email Address ____ Occupation ____ Spouse or Parent(s) Name ____

Person Financially Responsible

Name ____ Phone ____ Social Security Number ____

Address ____ Date of Birth ____

Dental History

Former Dentist's Name ____ City, State ____

Reason for last dental visit ____ Approximate Date ____

My child's mouth is:

- ○ very comfortable
- ○ moderately comfortable
- ○ uncomfortable

On a scale of 1 to 10, with 10 being the highest, please rate your child's fear of the dentist?

Is there anything we can do to help them feel more comfortable? ____

Are there any questions about dentistry you have never had adequately answered?

Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child under a physician's care now?	◯ Yes	◯ No	______
Have they ever been hospitalized or had a major operation?	◯ Yes	◯ No	______
Have they ever had a serious head or neck injury?	◯ Yes	◯ No	______
Are they on a special diet?	◯ Yes	◯ No	______
Is you child taking any medication, pills, or drugs?	◯ Yes	◯ No	
If yes, please list:			

Is your child allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa ☐ Other If yes, please explain: ______

Does your child have, or have you had, any of the following?

AIDS/HIV Positive	Cold Sores/Fever Blisters	Hives/Rash	Osteoporosis
Allergies/Hay Fever	Congenital Heart Disorder	Hemophilia	Psychiatric Care
Anemia	Diabetes	Hepatitis A, B and or C	Rheumatic/Scarlet fever
Asthma/Reactive Lungs	Epilepsy or Seizures	Hypoglycemia	Spina Bifida
Bleeding Disorder	Glaucoma	Kidney Problems	Stomach/Intestinal
Brain Injury	Hearing Problem	Liver Problems	Problems Tonsillitis
Cancer	Heart Condition	Lung Problems	Tuberculosis
Cerebral Palsy	High Blood Pressure		

Have you ever had any serious illness or injury not listed above? ◯ Yes ◯ No If yes, please explain: ______

University of Michigan Pediatric Sleep Questionnaire

While sleeping...

- does you child snore more than half the time?
- does our child always snore?
- does your child snore loudly?
- does your child have "heavy" or loud breathing?
- does your child have trouble breathing, or struggle to breath?

Have you ever seen your child stop breathing during the night?

Has a teacher or other supervisor commented that your child appears sleepy during the day?

Is your child at or above the 85th weight percentile?

This child often...

- does not seem to listen when spoken to directly?
- has difficult organizing tasks and activities?
- is easily distracted by extraneous stimuli?
- fidgets with hands or feet or squirms in seat?
- is 'on the go' or often acts as if 'driven by a motor'?
- interrupts or intrudes on others (e.g. butts into conversations or games)

Is it hard to wake your child in the morning

Does your child...

- tend to breathe through the mouth during the day?
- occasionally wet the bed?
- have a dry mouth on waking up in the morning?
- wake up with headaches in the morning?
- wake up feeling unrefreshed in the morning?
- have a problem with sleepiness during the day?

Did your child stop growing at a normal rate at any time since birth?

Total Checked:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT or GUARDIAN ______ DATE ______

Dental INSURANCE INFORMATION

Primary Dental Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Primary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self
☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

Secondary Dental Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Secondary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self
☐ Child ☐ Other

Medical Insurance Information

Employer | Employer's Address | Work Phone

Name and Address of Primary Insurance Company

☐ M ☐ F

Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Please email the completed form to info@bonddental.net
We look forward to meeting you!