ROBERT E. BRADLEY DDS
ROBERT J. ANGERAME DDS

124 E. Palatine Rd **(847)358-4090 office**
Palatine, Il 60067 **(847)358-4094 fax**

PATIENT INFORMATION

Date______________________

Name____ Preferred Name_______________Male/Female
Last First Initial

Birth Date____________________________ Social Security #______________________________

Address____
Street Apt# City State Zip

Phone____Email_________________________
Home Cell Work

Family Status: Single Married Divorced Widowed

Who will be responsible for this account?____

If patient is a minor, give parent or guardian's name____

Address____
Street Apt# City State Zip

Your Employer________________________How long employed_____________Employer Phone________________

Employer Address____
Box/Street City State Zip

EMERGENCY INFORMATION (Relative not living with you)
Name________________________________
Address______________________________
Telephone____________________________

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INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured______________________________Birth Date____________________SSN#_________________

Name of Employer____Insurance Co_________________________

Group#______________________ID#_________________________Ins Phone#___________________________

Claims Address____

SECONDARY INSURANCE

Name of Insured______________________________Birth Date_____________SSN#________________________

Name of Employer____Insurance Co_________________________

Group#_______________ID#_________________________________Ins Phone#___________________________

Claims Address____

How are you related to insured? Spouse Child Other

Please help those patients following you in our schedule by arriving on time to your appointments. This way we can minimize waiting time for all.

AUTHORIZATION

I affirm that the information I have provided is correct. I understand that unless prior arrangements have been made, I am responsible for payment at the time services are rendered. If insurance is involved, I understand that, at the time of service, I am responsible for the deductible or co-payment not covered by my insurance. I authorize my insurance company to send benefits to the offices of Drs. Bradley and Angerame.

____

Printed Name Signature Date

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MEDICAL HISTORY

DATE ____________________

PATIENT NAME______________________________________ BIRTH DATE____________________

It is important that we know about your Medical and Dental history. These facts have a direct bearing on your Dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Do you have or have had any of the following:

AIDS/HIV	Y N	Cancer	Y N	Fainting/Dizzy	Y N	Leukemia	Y N
Anaphylaxis	Y N	Chemotherapy	Y N	Glaucoma	Y N	Liver Disease	Y N
Anemia	Y N	Congenital Heart-		Headache	Y N	Lung Disease	Y N
Angina	Y N	Disorder	Y N	Herpes	Y N	Mouth Sores	Y N
Arthritis	Y N	Convulsions	Y N	Heart Attack	Y N	Mitral Valve-	
Atrial Fibrillation	Y N	Diabetes	Y N	Heart Disease	Y N	Prolapse	Y N
Artificial Heart-		Drug Addiction	Y N	Heart Murmur	Y N	Psychiatric Care	Y N
Valve	Y N	Easily Winded	Y N	Hemophilia	Y N	Pace Maker	Y N
Artificial Joint	Y N	Emphysema	Y N	Hepatitis A,B,	Y N	Radiation	Y N
Blood Disease	Y N	Epilepsy	Y N	or C		Rheumatic-	
High/Low		Excessive Bleeding	Y N	Hives	Y N	Fever	Y N
Blood Pressure	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Tonsillitis	Y N
Bruise Easily	Y N			Joint Pain	Y N	Tuberculosis	Y N
				Kidney Disease	Y N	Venereal Disease	Y N

Have you ever had any serious illness not listed above?____

Are you under a physician's care? Y N If yes, please explain____
Physician's name and address____

Have you ever been hospitalized or had a major operation? Y N If yes, please explain________________________
____
Have you ever had a serious head or neck injury? Y N If yes, please explain________________________________
____
Have you had a joint replacement? Y N If so, which joint and when?____________________________________
Have you ever been told to take pre-medication? Y N If yes, name and number of requesting Dr.
____

I hereby give the Office of Drs. Bradley and Angerame authorization to contact the physician recommending the medication needed. Patient Signature____

WOMEN:
Are you pregnant/trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

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Do you take, or have you taken Phen-Fen, or Redux? Y N
Do you take, or have taken Bisphosphonates? Y N
(i.e. Fosamax, Actonel, Boniva, Zometa, Aredia)
Are you on a special diet? Y N
Do you use tobacco products? Y N How often and what form?________________

Are you taking any medications, prescribed or over the counter? Y N If yes, Please list below

______________________ ______________________________ ______________________________

______________________ ______________________________ ______________________________

Are you allergic to the following?
Aspirin - Penicillin - Codeine - Sulfa Drugs – Acrylic- Metal -Latex -Local Anesthetic- Other
If yes, please explain____

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.
SIGNATURE OF PATIENT, PARENT OR GUARDIAN______________________________DATE_________