

**ROBERT E. BRADLEY DDS**  
**ROBERT J. ANGERAME DDS**

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

**TELL US ABOUT YOUR CHILD**

Today's Date: \_\_\_\_\_ Child's Home Phone#: (\_\_\_\_) \_\_\_\_\_ Social Security#: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Child's Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI  
Nickname: \_\_\_\_\_ M F School: \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
Street City State Zip  
Whom may we thank for referring you? \_\_\_\_\_

**PARENT INFORMATION**

Parent's Marital Status: Married Divorced Separated Widowed Remarried Single  
**Mother** Birth Date: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
Home Work Cell  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_  
**Father** Birth Date: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
Home Work Cell  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

**DENTAL HISTORY**

What is the primary reason for today's visit? \_\_\_\_\_  
Has the child experienced problems with previous dental work Y N  
Does the child brush his / her teeth daily Y N  
Floss his / her teeth daily Y N  
Previous / present Dentist: \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
(Please Circle)  
What did you like most about any dentist you have seen? \_\_\_\_\_ Least? \_\_\_\_\_

**Does the child have any of the following habits?**

\_Lip Sucking / Biting      \_Clenching / Grinding Teeth      \_Tongue / Cheek biting      \_Mouth breather  
\_Nail Biting      \_Thumb / Finger Sucking      \_Used Pacifier      \_Speech Problems  
\_Chewing on Objects      \_Nursing Bottle Habits      \_Tongue Thrust      \_Breast Fed

**ROBERT E. BRADLEY DDS**  
**ROBERT J. ANGERAME DDS**

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

**MEDICAL HISTORY**

Child's Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

Is the child currently under the care of a physician? Y N If yes, please explain: \_\_\_\_\_

**Please describe the child's current physical health:** Good/Fair/Poor **Are immunizations current?** Y N

Please list all the medications the child is currently taking: \_\_\_\_\_

Please list all the medications or other allergies child may have: \_\_\_\_\_

Anything you would like to discuss with the Doctor in Private? Y N

**Has the child had / experienced any of the following:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Aids / HIV+       | <input type="checkbox"/> Convulsions             | <input type="checkbox"/> Hives                 | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Skin Rash          |
| <input type="checkbox"/> Any Hospital      | <input type="checkbox"/> Handicaps/Disabilities  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hearing Impairment      | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Measles               |   |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Mitral Valve Prolapse |   |
| <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Mononucleosis         |   |

**Please discuss any serious medical problems the child experiences/ed** \_\_\_\_\_

**AUTHORIZATION**

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibly to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of the services rendered, any deductible, and co-payment that my insurance does not cover.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ROBERT E. BRADLEY DDS**  
**ROBERT J. ANGERAME DDS**

124 E. Palatine Rd  
Palatine, IL 60067

(847)358-4090 office  
(847)358-4094 fax

**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.