Robert E. Bradley, DDS&
Robert J. Angerame, DDS

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's 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

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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:

_Abnormal Bleeding	_Congenital Heart Defect	_High Blood Pressure	_Rheumatic Fever
_Aids / HIV+	_Convulsions	_Hives	_Scarlet Fever
_Allergies	_Diabetes	_Kidney Problems	_Sickle Cell Anemia
_Anemia	_Epilepsy	_Liver Problems	_Skin Rash
_Any Hospital	_Handicaps/Disabilities	_Low Blood Pressure	_Tonsillitis
_Asthma	_Hearing Impairment	_Lupus	_Tuberculosis
_Blood Transfusion	_Heart Murmur	_Measles	
_Cancer	_Hemophilia	_Mitral Valve Prolapse	
_Chicken Pox	_Hepatitis	_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&
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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.