Welcome

Welcome to Dr. Jayni Bradley's office, specializing in pediatric dental care. Thank you for choosing us. We go to great lengths to treat your child with patience, understanding, reassurance and compassion. Please complete the following:

Child's Name

First_____Middle_____Last_____
Preferred Name _____Date of Birth_____Age___Sex____
SS#_____-_____-_____ Home Phone ( )_____-_____
Address_____City_____State_____Zip_____
Name of School: _____ Grade: _____
Name and age of siblings:
_____
Whom may we thank for referring you to our practice?_____

Parent or Guardian Information

Mother

Name_____
Date of Birth_____
SS#_____-____-_____
Home Phone (____)_____-_____
Work Phone (____)_____-_____
Cell Phone (____)_____-_____
Text messages OK? Y N
Other Phone/Pager_____
Employer _____
Occupation _____
E-Mail Address: _____
Address (If different from above)
_____
_____

Father

Name_____
Date of Birth_____
SS#_____-____-_____
Home Phone (____)_____-_____
Work Phone (____)_____-_____
Cell Phone (____)_____-_____
Text messages OK? Y N
Other Phone/Pager _____
Employer _____
Occupation _____
E-Mail Address: _____
Address (If different from above)
_____
_____

Child resides with (Please circle): Mother Father Grandparents Other:
_____

In the event of an emergency whom may we contact if neither parent is available?
Emergency Contact _____Relation_____
Phone Number ( )_____-_____
Emergency Contact _____Relation_____
Phone Number ( )_____-_____

OVER

Dental/Medical History

How often does your child brush? _____
How often does your child floss? _____
Is your water fluoridated? _____
Does your child take fluoride supplements? _____
Has your child had any previous dental work? _____
Where?_____When?_____
Has your child ever had a negative experience with a dentist? ____
If so, what happened? _____

Does your child:			Has your child ever had:		
Suck Thumb/Finger	yes	no	Asthma	yes	no
Neurological Problems	yes	no	Handicaps	yes	no
Suck/ Bite Lip	yes	no	Tuberculosis	yes	no
Bite/Chew Nails	yes	no	Hepatitis	yes	no
Chew Hard Objects	yes	no	HIV/AIDS	yes	no
Grind Teeth	yes	no	Heart Problems	yes	no
Clench Jaws	yes	no	Sinus Problems	yes	no

Does your child have any allergies? ____
If so, please explain:_____
Has your child had any surgery or been hospitalized in the past? _____
If so, why?_____
Are there any other medical conditions that your child has now or has had?
_____
Who is your child's pediatrician and what is their phone number?
_____
When was their last visit to the pediatrician?_____
What was cause of that appointment?_____
Is your child taking any medications at this time? _____
If so, what?_____

Authorization & Release

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 child's health. It is my responsibility to inform the office of any changes in my child's health. I request and authorize dental services for my dependent. I consent to photography, filming, recording, and x-rays as needed in Dr. Bradley's professional judgement. I agree to be responsible for full payment of all services rendered on behalf of my dependant.

_____ _____
Signature of Parent/Guardian **Date**