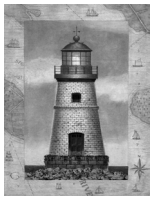

William J. Whitney, D.D.S.
Family Dentistry

Patient Information – Child

Name_____ D.O.B. _____ S.S.# _____

Sex: F M

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____

Student: Y N Full Time / Part Time Name of School _____

Contact Person in case of an Emergency _____ Phone # _____

Referred by / How you heard about our office: _____

Responsible Party

Name_____ D.O.B_____

Sex: F M Marital Status: Single Married Separated Divorced

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____

Work Phone_____ Email _____

Employer _____

Insurance Information

Policy Holder _____ D.O.B. _____ S.S.# _____

Relationship to Patient_____

Insurance Company _____ Group #_____ Subscriber ID_____

Employer _____

Employer Mailing Address_____

City _____ State _____ Zip _____

Work Phone_____

Please present your dental insurance card upon check-in.

PLEASE TURN OVER

MEDICAL HISTORY

*Physician / Medical Provider _____

*Currently under the care of a physician / medical provider? Y N
If yes, why? _____

*Serious illnesses, operations, or hospitalizations in the last 5 years? Y N
Explain: _____

*List ALL prescription medications, over-the-counter medications, vitamins, and herbal supplements taken on a regular basis: _____

_____

*Allergies? _____

*Ever had a reaction to Penicillin? Y N

*Ever had a reaction to local anesthetic, i.e. novacaine? Y N

*Ever had difficulty / complications following dental treatment? Y N
If yes, explain: _____

*Is antibiotic premedication needed before dental treatment? Y N
If so, why? _____

Currently has, or has ever had, any of the following? (Please circle)

Abnormal Bleeding	Chemotherapy	Heart Murmur	Lung Disease
AIDS/HIV Positive	Cold Sores	Heart Trouble/Disease	Mitral Valve Prolapse
Anemia	Congestive Heart Failure	Hemophilia	Mental Health Disorder
Anaphylaxis	Convulsions	Hepatitis A, B, C	Radiation
Artificial Heart Valve	Damaged Heart Valves	Herpes	Rheumatic Fever
Asthma	Diabetes	High Blood Pressure	Scarlet Fever
Autoimmune Disease	Eating Disorder	Hypoglycemia	Sinus Trouble
Blood Disease	Epilepsy/Seizures	Kidney Problems	Stroke
Blood Transfusion	Excessive Bleeding	Leukemia	Thyroid Disease
Breathing Problem	Fainting/Dizziness	Liver Disease	Tuberculosis
Cancer	Gastrointestinal Disease	Low Blood Pressure	Ulcers

Patient/Responsible Party Signature_____ **Date** _____

Relationship to Patient _____