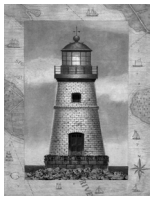

William J. Whitney, D.D.S.
Family Dentistry

Patient Information

Name _____ D.O.B. _____ S.S.# _____

Sex: F M Marital Status: Minor Single Married Separated Divorced

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Employer _____

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 (Only Complete if Different than Patient Information)

Name _____ D.O.B _____

Sex: F M Marital Status: Minor 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 _____

*Are you currently under the care of your physician / medical provider? Y N
If yes, why? _____

*Any 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? _____

*Have you ever had a reaction to Penicillin? Y N

*Have you ever had a reaction to local anesthetic, i.e. novacaine? Y N

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

*Do you currently take, or have you ever taken, Actonel, Boniva, or Fosomax? Y N

*Do you currently have, or have you ever had, an eating disorder, acid reflux, or GERD? Y N

*Do you need antibiotic premedication before dental treatment? Y N
If so, why? _____

WOMEN ONLY

Are you pregnant? Y N Maybe Are you taking an oral contraceptive / birth control pill? Y N

Are you currently nursing? Y N Are you taking a hormone replacement medication? Y N

TOBACCO USE

Have you ever used tobacco products? Y N Do you currently use tobacco products? Y N

Please indicate which type of tobacco use (circle): Chewing tobacco Cigars Cigarettes Pipe

Any history of controlled substance abuse? Y N

Do you currently have, or have you ever had, any of the following? (Please circle)

Abnormal Bleeding	Chest Pains	Genital Herpes	Mental Health Disorder
AIDS/HIV Positive	Chronic Pain	Heart Attack/Failure	Osteoporosis
Anemia	Cold Sores	Heart Murmur	Pacemaker
Anaphylaxis	Congestive Heart Failure	Heart Troubles/disease	Radiation
Angina	Convulsions	Hemophilia	Rheumatic Fever
Arthritis/Gout	Coronary Artery Disease	Hepatitis A, B, C	Rheumatoid Arthritis
Artificial Heart Valve	Damaged Heart Valves	Herpes	Scarlet Fever
Artificial Joint	Diabetes	High Blood Pressure	Shingles
Asthma	Drug Addiction	Hypoglycemia	Sinus Trouble
Autoimmune Disease	Emphysema	Kidney Problems	Stroke
Blood Disease	Eating Disorder	Leukemia	Thyroid Disease
Blood Transfusion	Epilepsy/Seizures	Liver Disease	Tuberculosis
Breathing Problem	Excessive Bleeding	Low Blood Pressure	Ulcers
Cancer	Fainting/Dizziness	Lung Disease	Venereal Disease
Chemotherapy	Gastrointestinal Disease	Mitral Valve Prolapse	

Patient/Responsible Party Signature_____ **Date** _____