Whitaker Dental

Welcome to our practice. We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child habits which will help keep their smile beautiful for their lifetime.

Date _____

Child's Name _____
Date of Birth _____ Sex: Male _____ Female _____
SS# _____ Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Child's Mother _____ Mother's SS# _____
Child's Father _____ Father's SS# _____

RESPONSIBLE PARTY
Name _____ Relationship _____
SS# _____ Employer _____
Name of Insurance Co _____

CHILD'S HABITS:
How often does your child brush his/her teeth? _____
Does your child:

Suck thumb/finger	YES	NO
Suck or bite lips	YES	NO
Bite or chew nails	YES	NO
Chew hard objects (pencils)	YES	NO
Grind teeth	YES	NO
Clench jaws	YES	NO

Is your child's drinking water fluoridated? YES NO
Does your child take fluoride supplements? YES NO

When was the last time your child has been to the dentist? _____
Has your child had difficulty with previous dental visits? _____ if yes, please describe _____
_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING: *Please circle*

Asthma
Tuberculosis
HIV/AIDS
Congenital Heart Defect
Allergies
Problems w/the immune system
Handicaps/disabilities
Hepatitis
Rheumatic Fever
Abnormal Bleeding
Convulsions/Epilepsy
Cancer
Diabetes
Hemophilia
Heart murmur
Respiratory problems

Please explain any medical condition your child may have _____
_____
Please list any medication (prescription or over the counter) your child takes _____
_____

Is your child **ALLERGIC** to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Latex □ Local Anesthetics □ Metal
Any other allergies □ Yes □ No If yes, Please explain: _____
_____

Signature of parent or guardian _____