BLACKER FAMILY DENTAL
11208 Quincy Avenue | Kansas City, MO 64137
816.763.8400 | www.mitchblackerdental.com

ADULT FORM

Personal Information

Date _____

Name _____ Social Sec # _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone # _____ Cell # _____ Email _____

Work Address _____ Work Phone _____ Occupation _____

Birth date _____ Sex: M _____ F _____ Spouse _____

# of Children _____ Parent or Guardian (if under 18) _____

Dental Insurance

1. _____ 2. _____

Who will pay for this account? _____ Referred by _____

Physician Name _____ Address _____ Phone # _____

Reason for dental visit _____

Medical History

Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **HAVE YOU EVER HAD OR HAVE:**

Asthma, hay fever, sinusitis, or other allergies	Yes_____	No_____
Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify: _____	Yes_____	No_____
Blood pressure or heart problems	Yes_____	No_____
Rheumatic fever or heart murmur	Yes_____	No_____
A pacemaker or open heart surgery	Yes_____	No_____
Diabetes, liver, kidney, thyroid or lung problems	Yes_____	No_____
Ulcers or stomach problems	Yes_____	No_____
Hepatitis or Jaundice	Yes_____	No_____
Epilepsy or nervous disorders	Yes_____	No_____
Bleeding or clotting disorders	Yes_____	No_____
Arthritis, Osteoporosis	Yes_____	No_____
Venereal Disease, Herpes	Yes_____	No_____

Please Complete Reverse Side

Acquired Immune Deficiency Syndrome (AIDS) Yes_____ No_____

Any other illness: _____ Yes_____ No_____

Do any wounds heal slowly or present complications? Yes_____ No_____

Are you currently taking any medicine? Specify: _____ Yes_____ No_____

Are you currently under the care of a physician? Yes_____ No_____

When was your last physical exam? _____

Have you ever been hospitalized? Date: _____ Reason: _____ Yes_____ No_____

Have you had X-ray treatments or chemotherapy? Yes_____ No_____

Are you presently on a diet? Yes_____ No_____

WOMEN: Are you taking birth control pills? Yes_____ No_____ Are you pregnant? Yes_____ No_____

Date of last dental exam _____

Date of last full mouth X-Ray _____ Where Taken _____

Have you had trouble from previous dental care? Yes_____ No_____

Do you have pain in your jaw or near your ears? Yes_____ No_____

Do you have any unhealed injuries or inflamed areas in or around your mouth? Yes_____ No_____

Have you experienced any growths or sore spots in your mouth? Yes_____ No_____

Does any part of your mouth hurt when clenched? Yes_____ No_____

Have you ever had Novocaine or other local anesthetic? Yes_____ No_____

Have you ever had Nitrous Oxide (laughing gas)? Yes_____ No_____

Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics? Yes_____ No_____

Have you ever had any difficult extractions in the past? Yes_____ No_____

Have you ever had prolonged bleeding following extractions in the past? Yes_____ No_____

Do your gums bleed? Yes_____ No_____

Do you have a bad taste in your mouth or mouth odor? Yes_____ No_____

Have you ever had instructions on the care of your gums? Yes_____ No_____

Do you chew on only one side of your mouth? If so, Why? Yes_____ No_____

Do you habitually clench or grind your teeth during the night or day? Yes_____ No_____

Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)? Yes_____ No_____

Do you snore or have trouble sleeping? Yes_____ No_____

Do you use CPAP? Yes_____ No_____

Is there any other problem not covered above that you would like to discuss? _____

_____

May we ask who recommended you to our office? _____