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

CHILD FORM

Personal Information

Date _____

Patient's Name _____ Patient's Birth Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mother's Work Phone _____ Father's _____

Cell Phone _____ Email Address _____

Father's Name _____ Occupation _____

For what company does Father work? _____

Mother's Name _____ Occupation _____

For what company does Mother work? _____

Dental insurance through Mother? Yes___ No___ Father? Yes___ No___

Social Security Number of Policy Holder _____

Physician's Name _____ Phone Number *(if available)* _____

Dental History

Are you aware of your child having any particular dental problems? Yes___ No___

Is he / she having any discomfort or pain? Yes___ No___ Where? _____

Last dental visit? _____ What was done at that time? _____

Medical History

Has there been any problem in your child's general health? *(Serious illness, hospitalization, surgery)*

Yes___ No___ If so, what was the problem? _____

_____

Date of your child's last medical check-up _____

Is he / she under a physician's care now? _____

If so, for what? _____

Does your child take any medication? *(This includes aspirin, vitamins, tonics, etc)* _____

_____

Please Complete Reverse Side

Does your child have / had any of the following diseases or problems?

Frequent headaches	Yes____	No____
Heart trouble, problems with blood pressure	Yes____	No____
Rheumatic fever, rheumatic heart disease	Yes____	No____
Pain in chest, shortness of breath, swollen ankles	Yes____	No____
Blood disorders, anemia	Yes____	No____
Blood test with unusual result	Yes____	No____
Abnormal bleeding, prolonged healing, bruises easily	Yes____	No____
Asthma, hay fever	Yes____	No____
Fainting spells, seizures	Yes____	No____
Hepatitis, jaundice, liver diseases	Yes____	No____
Arthritis	Yes____	No____
Kidney troubles	Yes____	No____
Tuberculosis, other lung ailments	Yes____	No____
Persistent cough, cough up blood	Yes____	No____
Diabetes	Yes____	No____
Radiation treatment for a tumor or other growth	Yes____	No____
Sores that did not heal within one week	Yes____	No____

Sensitive or allergic to?

Penicillin	Yes____	No____
Codeine	Yes____	No____
Novocaine	Yes____	No____
Aspirin	Yes____	No____
Anesthetics	Yes____	No____

Other Drugs _____

Does your child have any disease, condition or problem not listed above that you think the doctor should know about? Yes____ No____

_____

_____

Parent's Signature_____ Date_____