Permanent Chart **Family Practice Patients**

Adult Chart

Welcome to our family practice of dentistry. We appreciate your trust and confidence in our staff to treat your dental needs. Please fill out Sections I, II & III below and sign form if you have no questions.

I. Personal History

Name _____ Employer _____

Address _____ Address _____

City & Zip _____ City & Zip _____

Phone # _____ Phone # _____

Age _____ Birthdate _____ Insurance Co. _____

Sex _____ Marital Status _____ Soc. Sec. # _____

Spouse/Parent _____

Physician _____ Phone # _____

In Case of Emergency (Closest Relative or Friend)

_____ Address _____

Phone # _____ City & Zip _____

II. Medical History

Approximate date of last physical examination _____

		YES	NO	OFFICE USE ONLY
1.	Are you under any medical treatment now?	☐	☐	_____
2.	Have you had any major operations? If so, what?	☐	☐	_____
3.	Have you ever had a serious accident involving head injuries?	☐	☐	_____
4.	Have you had any adverse response to any drugs including penicillin?	☐	☐	_____
5.	Has a physician ever informed you that you had: A heart ailment?	☐	☐	_____
6.	High blood pressure?	☐	☐	_____
7.	Respiratory disease?	☐	☐	_____
8.	Diabetes?	☐	☐	_____
9.	Rheumatic fever?	☐	☐	_____
10.	Rheumatism or arthritis?	☐	☐	_____
11.	Tumors or growths?	☐	☐	_____
12.	Any blood disease? (Abnormal Bleeding)	☐	☐	_____
13.	Any liver disease?	☐	☐	_____
14.	Any kidney disease?	☐	☐	_____
15.	Any stomach or intestinal disease?	☐	☐	_____
16.	Any venereal disease?	☐	☐	_____
17.	Yellow jaundice or hepatitis?	☐	☐	_____
18.	Do you have night sweats accompanied by weight loss or cough?	☐	☐	_____
19.	Are you on a diet at this time?	☐	☐	_____
20.	Are you now taking drugs or medications?	☐	☐	_____
21.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐	_____
22.	Are you in general good health at this time?	☐	☐	_____
23.	Have any wounds healed slowly or presented any other complications?	☐	☐	_____
24.	Are you pregnant?	☐	☐	_____
25.	Do you have a history of fainting?	☐	☐	_____
26.	Have you ever had any X-Ray treatments (other than diagnostic)?	☐	☐	_____
27.	Have you ever been tested for and found positive for HIV/AIDS?	☐	☐	_____