LATROBE DENTAL ARTS
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MEDICAL-DENTAL HISTORY

DATE:_______________

NAME___________________________________**SOC SEC#** _______________

ADDRESS____

CITY__________________________**STATE**________**ZIP CODE**____________

AGE______ **DATE OF BIRTH**_________**MARITAL STATUS**_______________

TELEPHONE: RES_____________**WORK**_____________**CELL**____________

IF COLLEGE STUDENT – COLLEGE ATTENDING? ______________________

Purpose of Visit:___________________________**Referred by:**_______________

Date of last medical exam_____________**Date of last dental exam**_______________

Are you under the care of a physician?___________ **For What?** ________________

Please list all medication including OTC, vitamins, or herbal supplements:

____

____

____

Please list any known allergies include-latex?

____

Have you ever had a serious illness, operation or joint replacement? ______________

If Yes, What type and date? ____

____

Are you HIV Positive? YES NO DON'T KNOW (circle one)

Height ______ **Weight** ______ **Any tobacco use past or present? (type)** __________

Have you ever had any of the following: Please answer (Y) or (N)

Heart Murmur _______ **High Blood Pressure** __________
Asthma___________ **Liver problems**______________
Heart Disease______ **Kidney problems**______________
Hepatitis (TYPE)_________________ **Rheumatic fever**_____________
Diabetes (high blood sugar)________ **Thyroid problems**_____________
Excessive bleeding problem________ **Venereal disease**_____________
Eating Disorder _____________ **Lung Problems**______________
Epilepsy______ **Convulsive Seizures** ______ **Psychiatric Problems** ______

WOMEN ONLY: Are you pregnant?____________**Date due:**_______________

PLEASE COMPLETE OTHER SIDE

Are you satisfied with the appearance of your teeth?____________________________

Is there anything you would like to change about your teeth?____________________

Do you have difficulty with the following?

Chewing food ___________________ **Sensitive or hurting teeth** ____________

Bleeding gums ___________________ **Pain upon opening mouth** ____________

Frequent headaches _______________ **Fear of dental treatment** _____________

Have you had a jaw or facial injury? ____

Have you ever been told that you have sleep apnea?____________________________

ADDITIONAL INFORMATION WE SHOULD KNOW:

____

Who will be responsible for this account?______________________________________

Patient or Parent employed by:____

Address______________________________________**Position**_______________________

Name of Spouse___________________________________**Soc Sec#**__________________

Spouse employed by: ____

Address _______________________________________ **Position** ______________________

Name of Dental Insurance and policy numbers:_________________________________

____

Policy Holder Name ________________________________**Soc Sec #**_________________

Relationship to Patient ______________________________

Please list names and schools of all children in household:

____

____

MEDICAL UPDATES:

DATE SEEN	LIST/NONE	SIGNATURE