



ORTHODONTICS FOR KIDS AND ADULTS

Dr. Samuel Frank
Practice Limited to Orthodontics

Mount Lebanon: (412) 561-4561
Squirrel Hill: (412) 422-3111

Name	Nickname	Sex
Birthdate	Age	SS #
Address		
City	State	Zip Home Phone
Dentist	Physician	
How did you hear about our office?		
What questions would you like answered by Dr. Frank		

COMPLETE FOR A CHILD PATIENT:

School	Grade	Musical Instrument	
Sports	Hobbies/Interests		
Father's Name	Home Phone	Work Phone	Cell Phone
Address	City	State	Zip
Father's SS #	Employer		
Mother's Name	Home Phone	Work Phone	Cell Phone
Address	City	State	Zip
Mother's SS #	Employer		

COMPLETE FOR AN ADULT PATIENT:

Your Employer	Work Phone	
Spouse's Name	Employer	Work Phone
Spouse's SS #		

DENTAL INSURANCE INFORMATION: Please use information from your insurance card to complete this section.

Primary	Secondary		
Ins. Co.	Ins. Co.		
Address	Address		
City/State/Zip	City/State/Zip		
Phone #	Phone #		
Insured	Insured		
SS #	DOB	SS #	DOB
Group #	Group #		
Employer	Employer		

Person(s) responsible for payment & relationship to patient:

Please Note: SS # are for insurance information only.

PATIENT HISTORY:

Patient's Height

Weight

Father's Height

Mother's Height

In your own words, what is the problem?

Does anyone else in the family have a similar problem?

If so, who?

Names of other family members previously examined in this office:

Date of last cleaning?

Have you ever had any serious problems associated with previous dental treatment?

If so, please explain:

HEALTH HISTORY

Has the patient had any of the following:

Baby teeth removed by dentist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Major fall or accident involving head, face or teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Discomfort with bite	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Habits such as nail-biting, thumb-sucking, lip-biting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis or lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Speech problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Artificial joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty opening mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Noises or discomfort in/around jaw joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy, seizures, convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Jaw locking or getting stuck	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic fever, heart murmur or	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clenches jaw muscles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	other heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Grinds teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart surgery, heart pacemaker,	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	mitral valve collapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Venereal disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty breathing through the nose	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV positive/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(awake and/or asleep)			Hospitalized overnight	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cold sores	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Taking any medications	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug allergies/Penicillin, Latex, other	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If so, what?		
Hay fever, asthma or other allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If female, are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please add anything you feel is important: _____

Signature/Date: _____ Date Reviewed/Initials _____

Please inform us of any change in Medical History _____

