Dr. Samuel Frank

Practice Limited to Orthodontics

Name_____Male___Female___Nickname_____

Birthdate_____ Age_____

Street Address_____City_____State___Zip_____

Home Phone_____Cell Phone_____

Dentist's Name_____Physician's Name_____

How did you hear about our office?_____

What questions would you like answered by Dr. Frank?_____

_____

COMPLETE FOR A CHILD PATIENT:

Mother's Name_____Home phone_____Cell Phone_____

Address (If different from above)_____City_____State___Zip_____

Father's Name_____Home phone_____Cell Phone_____

Address(If different from above)_____City_____State___Zip_____

COMPLETE FOR AN ADULT PATIENT:

Employer_____Work Phone_____

Spouse's Name_____Cell Phone_____

DENTAL INSURANCE INFORMATION:

Primary Insurance_____ Secondary Insurance_____

Address_____ Address_____

City_____State_____Zip_____ City_____State_____ Zip_____

Phone Number_____ Phone Number_____

Insured ID or SS#_____ Insured ID or SS#_____

Insured BirthDate_____ Insured Birthdate_____

Insured Employer_____ Insured Employer_____

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? Yes___No___ If yes, who?_____

HEALTH HISTORY

Has the patient had any of the following:

- ☐ Baby teeth removed by dentist
- ☐ Major fall or accident involving head, face or teeth
- ☐ Discomfort with bite
- ☐ Habits such as nail-biting, thumb-sucking, lip-biting
- ☐ Speech problems
- ☐ Noises or discomfort in/around jaw joint
- ☐ Jaw locking or getting stuck
- ☐ Clenches jaw muscles
- ☐ Grinds Teeth
- ☐ Frequent headaches
- ☐ Sinus trouble
- ☐ Difficulty breathing through the nose (awake and/or asleep)
- ☐ Drug allergies/penicillin, Latex, other
- ☐ Cold sores
- ☐ Hay fever, asthma or other allergies
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Anemia
- ☐ Tuberculosis or ling disease
- ☐ Artificial joint
- ☐ Abnormal blood pressure
- ☐ Epilepsy, seizures, convulsions
- ☐ Rheumatic fever, heart murmur or other heart problems
- ☐ Heart surgery, heart pacemaker, mitral valve prolapse
- ☐ Venereal disease
- ☐ HIV positive/AIDS
- ☐ Hospitalized overnight
- ☐ Taking any medications If so, what?_____
- ☐ If female, are you pregnant?

Please add anything you feel is important:_____

_____

Signature/Date:_____ Date reviewed:_____

PLEASE INFORM US OF ANY CHANGE IN MEDICAL HISTORY