Dr. Dale Frank DDS
1858 Guernsey Ave.
Abington, Pa 19001

Patient Name: _____DOB_____
Home Address: _____
Preferred contact information:Phone or email:_____
Emergency contact number:_____Relationship to patient_____

If you are unsure of how to answer any of the questions below, please ask dental staff for help! Do you have or have you had any of the following? (please check)

	Yes	No		Yes	No
*Organ Transplant -- *Date:*			Epilepsy, Seizures, or Nervous System Disease		
*Joint Replacement (hip, knee, ankle, shoulder) -- *Date:*			Stroke		
			ALLERGY TO LATEX, iodine, red dye ,other…….. (circle all that apply)		
*Artificial Heart Valve -- *Date:*			Allergy to: metal or local anesthetics *(circle)*		
*Congenital Heart Disease, Defect, or Heart Murmur:			Cancer/tumors -- *Dates:*		
*Bacterial Endocarditis (SBE)			Chemotherapy or Radiation -- *Dates:*		
* Kidney Problems or Dialysis *(circle)*			Tuberculosis -- *currently* or *in past* *(circle)*		
*Spleen removed			Asthma, or other Lung Disease		
Steroid Use (e.g. prednisone) -- *Dates:*			Ulcers		
HIV or AIDS or do you believe you have been exposed?			Arthritis		
Lupus (SLE)			Osteoporosis		
Rheumatoid Arthritis			Thyroid Problems --- *High* or *Low* *(circle)*		
Diabetes: *Type I* *Type II* *(circle)*			Mental Health Condition:		
Other Immunosuppressive Condition:			Physical or Mental Disability that requires special consideration:		
Hepatitis -- *treated in past* or *currently active*					
Other Liver Disease			Chemical Dependency (alcohol /other drugs)		
Pacemaker / Defibrillator or other Artificial Device / Implant -- *Date*:			Do you smoke or chew tobacco?		
			If yes, are you interested in quitting?		
Congestive Heart Failure			Any other disease or condition?		
Heart Disease or Heart Attack -- *Dates:*					
Chest Pain / Angina			**WOMEN ONLY:**		
High Blood Pressure			Are you pregnant?		
Have you or are you taking blood-thinners?			Are you nursing?		
Anemia or Abnormal Bleeding or Bruising			Are you taking birth control?		

Please circle any of the following medications you have taken (usually for osteoporosis or as part of chemotherapy):
IV - Zometa (Zoledronate), IV - Aredia (Pamidronate), IV - Bonefos (Clodronate), Fosamax (Alendronate), Neridronate, Boniva (Ibandronate), Actonel (Risedronate), Didronel (Etidronate), Skelid (Tiludronate), Loron, Olpadronate.

List any medications that you are allergic to or which make you sick: _____

_____

List medications you currently take (including over-the-counter drugs): _____

Date of last medical appointment_____ Primary Care Provider Name _____

Have you ever been hospitalized? _____ When and What for? _____

IMPORTANT! The answers I have given above are true to the best of my knowledge. I am signing below on behalf of myself or the below named minor in my guardianship.

_____ _____
Signature (Patient or guardian if patient is a minor) *Date*

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, _____, hereby request that you provide me with copies of all of my dental records and all other records regarding my care, including diagnostic x-rays and radiographs (digital and film), copies of prescriptions, plans of care, clinical notes, correspondence from dental and medical specialists, laboratory results, and insurance related documents.

Kindly forward copies of my complete records to:

Dale Frank, DDS & Associates, LLC

1858 Guernsey Avenue

Abington, PA 19001

215-690-4435

Please contact Dr. Frank's practice with any questions regarding the copying and transfer of my records.

_____ _____

(Signature of Patient or Legal Representative) Date

_____ _____

Print Name of Patient Signature of Witness

If signed by Legal Representaive, Relationship to Patient: _____