Print Form

PATIENT REGISTRATION

Maureen L. O'Flanagan, D.D.S.

First Name: _____ Last Name: _____ Date: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

PATIENT INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security Number: _____

E-Mail: _____ ☐ I would like to receive correspondences via e-mail

Emergency Contact Name: _____ Emergency Contact Phone: _____

Employer Name: _____ Pharmacy Phone: _____

RESPONSIBLE PARTY (If someone other than the patient)

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Social Security Number: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

DENTAL INSURANCE INFORMATION

Group Number: _____ ID Number: _____

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer: _____ Employer Address: _____

Employer City, State, Zip: _____ Employer Address 2: _____

Insurance Company: _____ Insurance Company Address: _____

Insurace Company City, State, Zip: _____ Phone Number: _____

Insurance Social Security Number: _____ Insurance Date of Birth: _____

SECONDARY DENTAL INSURANCE INFORMATION

Group Number: ID Number:

Name of Insured: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer: Employer Address:

Employer City, State, Zip: Employer Address 2:

Insurance Company: Insurance Company Address:

Insurace Company City, State, Zip: Phone Number:

Insurance Social Security Number: Insurance Date of Birth:

MEDICAL HISTORY

Patient Name:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician for any illness or health problem? (for the last two years) ☐ Yes ☐ No ☐ N/A

Date of Last Exam

Physicians: 1: Phone: Speciality:

Physicians: 2: Phone: Speciality:

Physicians: 3: Phone: Speciality:

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ☐ N/A

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A

Do you use tobacco? ☐ Yes ☐ No ☐ N/A

Are you on a special diet? ☐ Yes ☐ No ☐ N/A

Do you used controlled substances? ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codine ☐ Acrylic ☐ Latex ☐ Local Anesthetics ☐ Erythromycin

☐ Other

MEDICAL HISTORY

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Dis.
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/ Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeats
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever*
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Dis.
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A

Comments:

*Condition may require medication

N/A = Not Answered by Patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____