ORAL SURGEONS OF INDIANA

DENISE A. FLANAGAN, D.D.S. • MARK W. ANDERSON, D.D.S., M.S.

Board Certified Physicians

OFFICE 317.876.1095 • FAX 317.875.7275

8240 Naab Road, Suite 355, Indianapolis IN 46260

OralSurgeonsIN.com

First Name ______________________ M.I.______ Last Name ____________________________ Nickname ____________________

Please Circle One: Mr. Ms. Mrs. Miss Dr. Male or Female E-Mail Address ____

Date of Birth ____________________________ Age __________ Social Security # ______________________________

Street Address ______________________________________ City __________________________ State __________ Zip __________

Home Phone # __________________________ Cell Phone # __________________________ Work Phone # __________________________

Dentist Name ____ *Referred* By ______________________________________

Who will be responsible for your account? _____Self _____Spouse _____Mother _____Father _____ Other ____________________

••••• If Self, Skip to Next Paragraph ••••

Name ____ Social Security # ______________________________________

Street Address ____ City ____________________ State ______ Zip ____________

Home Phone # __________________________ Cell Phone # __________________________ Work Phone # __________________________

Your Employer ____ Employer Phone # __________________________________

Spouse Name ________________________________ Date of Birth __________ Social Security # __________________________

Street Address ______________________________________ City __________________________ State __________ Zip __________

Cell Phone # ____________________________ Employer ____________________________________ Work Phone # ________________

PRIMARY DENTAL INSURANCE COMPANY

Name ____

Phone # ____

Insurance ID# _______________________________________

Group # __________ Group Name _________________________

Insured's Name ______________________________________

Date of Birth ____

PRIMARY MEDICAL INSURANCE COMPANY

Name ____

Phone # ____

Insurance ID# _______________________________________

Group # ________ Group Name ___________________________

Insured's Name ______________________________________

Date of Birth ____

SECONDARY DENTAL INSURANCE COMPANY

Name ____

Phone # ____

Insurance ID# _______________________________________

Group # __________ Group Name _________________________

Insured's Name __________ Date of Birth __________________

SECONDARY MEDICAL INSURANCE COMPANY

Name ____

Phone # ____

Insurance ID# _______________________________________

Group # ________ Group Name ___________________________

Insured's Name ________ Date of Birth ____________________

I agree to pay for all professional fees & treatments at the time of service &/or my estimated amount not covered by my insurance for the above patient or myself. I realize that I am also responsible for full payment of fees not paid by my insurance company within 30 days of the date of service. I also agree to pay interest at the rate of 1.5% monthly on any balance over 45 days of the date of service, any collection agency fees, attorney fees, and court costs should these means become necessary

Signature of Responsible Party ____ Date ____________________

DENISE A. FLANAGAN, D.D.S. • MARK W. ANDERSON, D.D.S., M.S.

Board Certified Physicians

Medical History Today's Date ______________________

Are you currently under a Doctor's care? _____Yes _____No If Yes ~ Please Explain ______________________________

____

____

Physician's Name ______________________________ Phone Number ______________________

Current Medications ____

____

____

Herbal Medicines? ____

Do you smoke or use smokeless tobacco? _____No _____Yes _____How Much? ______________________

WOMEN ONLY Are you currently taking birth control _____Yes _____No

Are you Pregnant or Nursing at this time? ___Yes ___ No If pregnant estimated due date? ______________

OBGYN Name & Phone Number ____

If nursing – Pediatrician Name & Phone Number ____

Do you now or have you ever experienced pain or discomfort in your jaw joint? ______ Yes _____ No

Clicking/popping of your jaw joint, pain near ear, difficulty opening your mouth, grind, or clench teeth? _____Yes _____ No

Please CIRCLE any of the following conditions that you have had or presently have:

History of Endocarditis	Neurological Disorder	Hepatitis	Kidney Disease
Congenital Heart Disease	Epilepsy / Seizures	Liver Disease	Diabetes
Artificial Heart Valves	Fainting	Thyroid Problems	Arthritis
Heart Murmur	Mental Health Problems	Immune System Disorder	Glaucoma
Rheumatic Heart Disease	HIV positive	Blood Disorders	Allergies
Heart Attack	AIDS	Angina	Knee or Hip Replacement
Asthma	Sinus Trouble	High Blood Pressure	Venereal Disease
Bronchitis	Frequent Mouth Sores	Low Blood Pressure	Mouth Sores
COPD	Persistent/Swollen Neck Glands	Stroke	Cancer
Emphysema	Stomach Ulcers	ANY Heart Condition	Radiation Treatment
Tuberculosis (TB)	Colitis		

Are you currently taking or have EVER been treated with: Zometa (Zoledronic acid) or Aredia (Pamidronatic) ____Yes ____ No

Are you ALLERGIC or had a bad reaction to: Local Anesthetic (Novacaine) Aspirin or Ibuprofen Penicillin/Amoxicillin Other Antibiotics Barbiturates/Sedatives Codeine or Pain Killers Latex or Rubber Products

Other Allergies? Please list: ____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office/doctor of any changes in my medical status. I authorized the dental staff to perform necessary dental services with my informed consent that I may need during diagnosis and treatment. I agree to pay for all professional services rendered by this office. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC and the ADA.

______________________________ ______________ ______________

Signature of Person Completing Health History Date Doctor Initials