

MICHAEL FLATLEY DDS, PS

P 253.853.4955
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Welcome

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely in ink.

Patient Information

Name _____ Date of Birth _____

Address _____

City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-mail address _____

Circle Appropriate: Minor Single Married Divorced Widowed Separated

Person to Contact in Case of an Emergency? _____ Phone # _____

Responsible Party

Person Responsible for this account _____

Billing Address (if different from above) _____

City _____ St _____ Zip _____ SS# _____

Home Phone _____ Work Phone _____

Insurance Information

Name of Insured _____ Date of Birth _____ SS # _____

Name of Employer _____ Wk Ph: _____

Insurance Company _____

Policy ID# _____ Union or Local# _____ Group # _____

Ins Co. Address _____

City _____ St _____ Zip _____

Insurance Phone Number _____

Secondary Dental Insurance

Name of Insured _____ Date of Birth _____ SS # _____

Name of Employer _____ Wk Ph: _____

Insurance Company _____

Group# _____ Policy ID# _____ Union or Local # _____

Ins Co. Address _____

City _____ St _____ Zip _____

Insurance Phone Number _____

WHOM may we thank for referring you to us? _____

I acknowledge that I am financially responsible for all charges, regardless of any insurance coverage. I acknowledge that any past due amount after 90 days will incur finance charges. I also authorize the doctor to use and show any case photos and or models that may be taken.

SIGNATURE _____ DATE _____

4423 Point Fosdick Dr., Suite 304, Gig Harbor, WA 98335

Patient Medical History (CONFIDENTIAL)

Physician_____Office Phone_____Date of Last Exam_____

1. Are you under medical treatment now?_____
2. Have you ever been hospitalized for any surgical operation or serious illness?_____
3. Are you taking any medication(s) including non-presciption medicine?_____If yes, what medications are you taking?_____
4. Do you use alcohol ? _____ tobacco?_____
5. Do you use a Pace Maker ?_____
6. Are you allergic to or have had any reactions to the following:(PLEASE CHECK FOR YES ONLY)

Local Anesthetic___	Penicillin ___	Antibiotic ___
Sulfa Drugs___	Sedatives ___	Sulfites (Preservative) ___
Codeine ___	Aspirin ___	Latex (Rubber Gloves) ____
Barbiturates ___	Other: _____	

7. Woman: Are you pregnant or think you might be?____Are you nursing?____Are you taking birth control pills? ____ **NOTE**: Birth control may be adversely affected by antibiotic use
8. Do you have or have had any of the following: (**PLEASE CHECK FOR YES ONLY**)

High Blood Pressure ___	Swollen Ankles ___	Low Blood Pressure ___	Glaucoma ___
Heart Attack ___	Faint/Seizures ___	Epilepsy/Convulsions ___	Stroke ___
Rheumatic Fever ___	Hayfever/Allergies___	Leukemia ___	Cancer ___
Joint Replacement____	Tuberculosis ___	Kidney Disease ___	Liver Disease___
Heart Disease___	Thyroid Problems ___	Emphysema ___	Ulcers ___
Chest Pains___	Cardiac Pace Maker ___	Aids or HIV Infection ___	Herpes ___
Heart Murmur ___	Diabetes___	Radiation Therapy ___	Asthma___
Angina___	Frequently Tired___	Rheumatoid Arthritis ___	
Gout___	Cholesterol ___	Mitral Valve Prolapse ___	

Patient Dental History

1. Do you have any specific concerns regarding your teeth and/or gums? _____
2. If you could change anything about your teeth and/or smile, what would you change?_____
3. Do your gums bleed when you brush and/or floss?_____
4. Are your teeth sensitive to hot, cold, sweet or sour liquids/foods?_____
5. Do you feel pain with any of your teeth? _____
6. Do you have any sores in or near your mouth? _____
7. Have you had any head or neck injuries? _____
8. Have you ever experienced any of the following problems in your jaw:

Clicking ___	Pain (joint, ear, side of face) ___
Difficult opening or closing ___	Difficult ___

9. Do you have frequent head aches that originate in front of your ears?_____
10. Do you clench or grind your teeth? _____
11. Do you bite your lips or cheeks frequently? _____
12. Have you had any orthodontic treatment in the past?_____
13. Have you ever had instructions on the correct way to brush your teeth and care for your gums?_____

NITROUS is available in this office ($35. Per hour). Is this **possibly**, something, you will want to use or try when having dental treatment done? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE _____DATE_____

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