MICHAEL RAGAN, D.D.S.

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SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Patient Information Sheet (C)

Date:______________________________

Name: ____ Nickname:______________________________

Patient Address:___________________________________ City:_______________ State:________ ZIP:__________

Phone (for reminder calls)________________________ Other Phone Number:_____________________________

E-Mail Address (for reminder emails): ____

Birthdate:_______________ Age:_______________ Sex:_________________ Race:__________________

School/Employer:_______________________________ Grade/Position:______________________________

Interests/Sports:_______________________________ Musical Instruments Played:_____________________

Responsible Parties: (Primary denotes the person with the Primary Insurance Coverage)

Primary: Mother Father Step Parent Self Other (specify)_______________

Circle all that apply Single Married Widowed Divorced Other (specify)_______________

Mr. Mrs. Miss Ms. Dr.

Name:______________________________________ DOB:_________________ SS#:___________________

Address:________________________________City:______________ State:________ ZIP:______________

E-Mail Address:____

Employer:______________________ Address:____________________________________ How Long?:______

Telephone: Home: ____________________ Work: ____________________ Cell: ____________________

Insurance Carrier:_____________________ Address:____

Insurance Carrier Telephone:_________________________________ Group Number:_____________________

Member/Subscriber ID Number: __________________________

Secondary: Mother Father Step Parent Self Other (specify)_______________

Circle all that apply Single Married Widowed Divorced Other (specify)_______________

Mr. Mrs. Miss Ms. Dr.

Name:______________________________________ DOB:_________________ SS#:___________________

Address:________________________________City:______________ State:________ ZIP:______________

Employer:______________________ Address:____________________________________ How Long?:______

E-Mail Address:____

Telephone: Home: ____________________ Work: ____________________ Cell: ____________________

Other Responsible Parties:____

Dentist:____ Last Cleaning Visit____________________

Who may we thank for referring you to our office? ____

Did you see us: Advocate Dallas Child D Magazine School Publication or Auction____________________
Our Web Site Other:__________________________

Reason for Consultation:____

Over

Please circle all relating to patient's history

Medical				Allergies	Dental
None	Chemotherapy	Heart Attack	Mitral Valve Prolapse	**None**	**None**
AIDS/HIV+	Chest pains	Heart Murmur	Operations	Drugs	Clicking of jaw
Alcohol/Drug abuse	Congenital Defect	Heart condition	Pneumonia	Latex	Cold Sores/Herpes
Anemia	Diabetes	Hepatitis/ Liver Problem	Pregnant	Metals	Painful chewing
Artificial Joints	Downs Syndrome	High Blood Pressure	Prolonged Bleeding	Plastics	Periodontal problems
Artificial Valve	Endocrine problems	Hospitalized	Radiation Treatment	Rubber	Speech problems
Arthritis	Emotional disorders	Immune problems	Rheumatic Fever	Seasonal	TMJ problems
Asthma	Epilepsy	Joint Replacement	Scoliosis		Tooth Grinding
Autoimmune	Fainting, Dizziness	Kidney problems	Seizures/ Convulsions		Unfinished Dental work
Bleeding Disorders	Glaucoma	Low Blood Pressure	Sinus Problems		
Bone Disorders	Handicap/ Disabled	Muscular disorders	Stroke		
Bulimia	Headaches	Neck pain-Chronic	Tuberculosis		
Cancer	Hearing Problems	Nervous Disorders	Venereal Disease		
Cerebral palsy		Organ Transplant			

Please explain any circled items above:____

Any other disease, problems or allergies not listed above?:______________________________

Current medications:____

Female: Has she started menstruating?________ At What Age?______ Wisdom teeth extracted?______

Any face or mouth injuries?__________________ Any missing teeth?__________________

Normally breath through the mouth while awake or sleeping?________________________

Do gums bleed when brushing or flossing?__________________________________

Previous orthodontic treatment?__________ Have other orthodontists been consulted?____________

Are there any mouth habits past or present(thumb or finger sucking, pacifier, mouth breathing, etc.)?________

Have tonsils and adenoids been removed?________ Other concerns?____________________

Names and ages of brothers and sisters?____________________________________

Would you like us to see anybody else in the family?______________________________

The undersigned hereby authorizes Dr. Ragan and/ or his staff to perform the examination including x-rays, photo's and study models. I authorize the discussion and/ or consultation of the provided information, examination and records with dentists, dental specialists, and other health care professionals as needed.

Orthodontic appliances are composed of very small parts that could be accidentally swallowed, aspirated (inhaled), impacted and could irritate or damage the oral tissues. If unsure of the location or the object is inhaled or ingested, a chest x-ray may be required to isolate the object. The undersigned authorizes all forms of treatment including separators, bands and braces with knowledge and understanding of the risks. This shall remain in force and effective until cancelled by either party. All fee's for services rendered are due at the conclusion of each appointment, unless other financial arrangements have been made.

Signature:____________________________ Date:______________________

Print Name:____________________________Relationship to Patient:______________

Office Use Only:

Reviewed Info verbal and written:__________ Date:__________ BP:_____/_____ Pulse:______

Other Info:____