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:_____