Ragan ORTHODONTICS

Michael Ragan, D.D.S.
Specialist in Orthodontics and Dentofacial Orthopedics

8100 Lomo Alto, Suite 204, Dallas, Tx 75225 • 214-363-8893
6316 Gaston Ave., Dallas, Tx 75214 • 214-364-3900
12300 Ironwood Rd., Suite 220, Dallas, Tx 75244 • 972-233-4439

PATIENT INFORMATION SHEET

Date:_____

Patient's Name: _____Nickname:_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone (for reminder calls)_____ Other Phone Numbers(Cell or Pager):_____

E-Mail Address:_____

Birthdate:_____ Age:_____ Sex:_____ Race:_____

School:_____ Grade:_____

Interests/Sports:_____ Musical Instruments Played:_____

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

Primary: Mother Father Step Parent Other (specify)_____
Circle all that apply Single Married Widowed Divorced Other (specify)_____

Name:_____ DOB:_____ SS#:_____

Address:_____City:_____ State:_____ ZIP:_____

E-Mail Address:_____

Employer:_____ Address:_____

Telephone: Home: _____ Work: _____ Cell: _____

Dental Insurance Carrier:_____Insurance Phone:_____

Group Number:_____Member/Subscriber ID Number: _____

Drivers License Number:_____

Secondary: Mother Father Step Parent Other (specify)_____
Circle all that apply Single Married Widowed Divorced Other (specify)_____

Name:_____ DOB:_____ SS#:_____

Address:_____City:_____ State:_____ ZIP:_____

E-Mail Address:_____Telephone: Work: _____ Cell:_____

Other Responsible Parties:_____

Dentist:_____ Last Cleaning Visit_____

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

(OVER)

Please Circle all relating to patients History

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

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:_____