

# 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 Numbers (Cell or Pager): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

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: \_\_\_\_\_ Other: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: Insurance Carrier: \_\_\_\_\_ Group 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: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_

Child's Custodial Guardian(s): \_\_\_\_\_

Who is financially responsible for the child? \_\_\_\_\_

Dentist: \_\_\_\_\_ Last Cleaning Visit \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

**Please Circle all relating to patients History**

Medical				Allergies	Dental
<b>None</b>	Chemotherapy	Heart Attack	Mitral Valve Prolapse	<b>None</b>	<b>None</b>
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		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: Have you 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: \_\_\_\_\_