PATIENT INFORMATION - ADULT

ALL ABOUT YOU

Name: _____
Last First

I prefer to be called: _____

☐ Male ☐ Female Birthdate ___/___/___ Age _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SSN: _____

Home Address: _____

City _____ State _____ Zip _____

Home # ( ) _____ Email _____

Occupation: _____

Employer: _____ How long? _____

Work# ( ) _____ Ext: _____

Work Address: _____

City _____ State _____ Zip _____

Where/When is the best time to reach you? _____

Whom may we thank for referring you? _____

Emergency Contact: _____

Phone # ( )

OTHER CONTACT INFORMATION

His/Her Name: _____
Relation: _____
Employer: _____
Phone# ( ) _____

DENTAL HISTORY

General Dentist:
Date of Last Exam:
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
What are the main concerns that you would like orthodontics to address?

_____

	Yes	No
Have you ever had or been evaluated for orthodontic treatment?		
Have there ever been any injuries to the face, mouth, teeth or chin?		
Do you have any missing or extra permanent teeth?		
Do you like your smile?		
Do your gums ever bleed?		
Do you generally breath through your mouth?		
If yes: While awake? ☐ While asleep? ☐		
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?		

RAGLIN DENTAL GROUP
SPECIALIZING IN ORTHODONTICS

Dr. Alisa J. Raglin, D.D.S.
Specializing in Orthodontics
www.raglinortho.com

MEDICAL HISTORY:

Your current medical condition is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐Yes ☐ No
Please explain: _____

_____

Physician's Name: _____
Are you taking any prescription/over the counter ☐Yes ☐ No drugs? If yes, please list each one:

_____

_____

Have you ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Heart Surgery/Pace Maker
Y	N	Anemia/Radiation Treatment	Y	N	Hemophilia
Y	N	Artificial bones/Joints/Valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	HIV+/AIDS
Y	N	Cancer/Chemotherapy	Y	N	Hospitalization
Y	N	Diabetes	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Tuberculosis	Y	N	Psychiatric Problems
Y	N	Difficulty breathing	Y	N	Rheumatic Heart Disease
Y	N	Glaucoma	Y	N	Scarlet Fever
Y	N	Drug or Alcohol Abuse	Y	N	Shingles
Y	N	Emphysema	Y	N	Sinus Problems
Y	N	Epilepsy/Seizures/Fainting	Y	N	Severe Headaches
Y	N	Fever Blisters/Herpes	Y	N	Frequent Headaches
Y	N	Heart Murmur	Y	N	Heart Attack
Y	N	Ulcers/Colitis	Y	N	Venereal Disease

Are you pregnant? ☐ Yes ☐ No

Please list any other serious medical condition(s) that you have ever had or have:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Metals
Y	N	Dental Anesthetics	Y	N	Plastics
Y	N	Erythromycin	Y	N	Penicillin
Y	N	Tetracycline	Y	N	Other

Please list any other drugs/materials that you are allergic to:

_____

_____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

_____
Reviewed Date