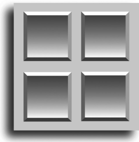

John A. Colgan, DMD, MS, PSC
Practice Limited to Orthodontics
105 Kiana Court • Paducah, Kentucky 42001
Phone (270) 534-8776

WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.
Thank you for your cooperation.

Patient Information

Name ______________ (Last) ______________ (First) ______________ (Middle) Sex ______ Marital Status ______________

Address ______________ (Street) ______________ (City) ______ (State) ______ (Zip)

Birthdate ______________ (MM/DD/YYYY) E-mail ______________ Social Security # ______________ (999-000-9999)

Home Phone ______________ (999-000-9999) Cell Phone ______________ (999-000-9999) Work Phone ______________ (999-000-9999) ext. ______

Employer ______________ Occupation ______________ No. Years Employed ______

General Dentist ______________ Last Visited ______________

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

Spouse / Additional Contact Information

Name ______________ (Last) ______________ (First) ______________ (Middle) Marital Status ______________

Address ______________ (Street) ______________ (City) ______ (State) ______ (Zip)

Birthdate ______________ (MM/DD/YYYY) E-mail ______________ Relationship to Patient ______________

Home Phone ______________ (999-000-9999) Cell Phone ______________ (999-000-9999) Work Phone ______________ (999-000-9999) ext. ______

Employer ______________ Occupation ______________ No. Years Employed ______

Insurance Information

Policy Owner's Name ______________ Policy Owner's Social Security # ______________ (999-000-9999)

Policy Owner's Birthdate ______________ (MM/DD/YYYY) Relationship to Patient ______________

Policy Owner's Employer ______________ Employer's Address ______________

Insurance Company ______________ Group No. (plan, local, or policy) ______________

Insurance Co. Address ______________ Insurance Phone No. ______________

Secondary Insurance

Policy Owner's Name ______________ Policy Owner's Social Security # ______________ (999-000-9999)

Policy Owner's Birthdate ______________ (MM/DD/YYYY) Relationship to Patient ______________

Policy Owner's Employer ______________ Employer's Address ______________

Insurance Company ______________ Group No. (plan, local, or policy) ______________

Insurance Co. Address ______________ Insurance Phone No. ______________

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If Yes, explain ____________________

Physician ____________________ Address ____________________

Are you pregnant ☐ Yes ☐ No If so how many weeks? ____________________

What are the main concerns that you would like orthodontics to accomplish? ____________________

Has the patient ever been evaluated for orthodontic treatment? ____________________

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Does the patient have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the patient ever had an injury to: (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No If Yes, explain ____________________

Do your gums bleed? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Does/Has the patient ever had any of the following habits? ☐ Lip Sucking/Biting ☐ Nail biting ☐ Prolonged Bottle/Pacifier ☐ Clenching/Grinding Teeth ☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/ Finger Sucking

Is the patient allergic to the following?	List all drugs the Patient is currently taking	List any serious medical condition(s) treated
☐ Aspirin ☐ Erythromycin ☐ Codeine ☐ Penicillin ☐ Tetracycline ☐ Latex ☐ Any Metals/Plastics ☐ Other Allergies/Sensitivities: ____________________		

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form ____________________ Date ____________