WELCOME

We would like to welcome you and your child 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.

COLGAN
ORTHODONTICS
JOHN A. COLGAN • DMD-MS-PSC

John A. Colgan, DMD, MS, PSC
Practice Limited to Orthodontics

2 LOCATIONS:

PADUCAH
105 Kiana Court
Paducah, Kentucky 42001
(270) 534-8776

MURRAY
1302 Johnson Blvd.
Murray, KY 42071
(270) 753-1430

Patient Information

Name ______________________________ Sex ________
Last First Middle

Address ______________________________
Street City State ZIP

Birthdate ______________ Age ________ E-mail ______________________
MM/DD/YYYY

Cell Phone ______________ General Dentist ______________ Last Visited ______________
999-000-9999 999-000-9999

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

Responsible Party Information

Guardian

Name ______________ ______________ ______________
Last First MIddle

Address ______________ ______________ ________ ________
Street City State Zip

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

Cell Phone ______________ Work Phone ______________ ext. ________
999-000-9999 999-000-9999

Employer ______________ Occupation ______________ No. Years Employed ________

Relationship to Patient ______________

Guardian

Name ______________ ______________ ______________
Last First MIddle

Address ______________ ______________ ________ ________
Street City State Zip

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

Cell Phone ______________ Work Phone ______________ ext. ________
999-000-9999 999-000-9999

Employer ______________ Occupation ______________ No. Years Employed ________

Relationship to Patient ______________

Dental / Orthodontic Insurance Information

Policy Owner’s Name ______________ Policy Owner’s Employer ______________

Policy Owner’s Date of Birth ______________ Policy Owner’s SS# or ID# ______________

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

Insurance Co. Address ______________ Insurance Phone No. ______________

Do You have Dual Coverage? ☐ Yes ☐ No

MORE ON OTHER SIDE

Secondary Dental 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. ______________________

General Information

School ______________________

Hobbies

Sibling(s), Age(s)	Treated by Dr. John?
______________	Yes/No
______________	Yes/No
______________	Yes/No
______________	Yes/No

Dental History

What would you like to change most about your smile?______________________

Has the patient ever been evaluated for orthodontic treatment?______________________

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

Any sounds when the jaws are moved? ☐ Yes ☐ No

Does the patient have speech problems? ☐ Yes ☐ No If Yes, explain______________________

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

Medical History

Medical Physician?______________________Phone______________________ Last Visit______________

Is the child currently under the care of a physician? ☐ Yes ☐ No If Yes, explain

Has puberty begun? ☐ Yes ☐ No Has menstruation (period) begun? ☐ Yes ☐ No

Has the patient tonsils or adenoids been removed? ☐ Yes ☐ No When?______________________

Is the child 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 confidence and it is my responsibility to inform this office of any changes in my child's 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 ____________