PADUCAH
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Paducah, Kentucky 42001
(270) 534-8776

COLGAN TRITLE ORTHODONTICS

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

John A. Colgan, DMD, MS, PSC • Andrew B. Tritle, DMD
Practice Limited to Orthodontics

Patient Information

Today's Date _____ Name _____ Sex _____
(First / Middle / Last)

Birthdate _____ Marital Status _____ Social Security # _____
(MM/DD/YYYY)

Address _____
(Street / City / State / ZIP)

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

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

Spouse / Additional Contact Information

Today's Date _____ Name _____
(First / Middle / Last)

Birthdate _____ Marital Status _____ Social Security # _____
(MM/DD/YYYY)

Address _____
(Street / City / State / ZIP)

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ No. Years Employed _____

PRIMARY DENTAL INSURANCE

Policy Owner's Name _____ Policy Owner's SS or ID # _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____

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

Insurance Dental Claims Address _____ Insurance Phone No. _____

SECONDARY DENTAL INSURANCE

Policy Owner's Name _____ Policy Owner's SS or ID # _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____

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

Insurance Dental Claims Address _____ Insurance Phone No. _____

(MORE ON OTHER SIDE)

Medical History

Medical Physician _____ Office Phone _____

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

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

Have you ever been evaluated for orthodontic treatment? _____

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

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to: (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin ☐ Jaw

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

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

Have you 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

Are you allergic to the following?	List all drugs you are currently taking	List any serious medical condition(s) treated
☐ Aspirin ☐ 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 confidence, 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 _____