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

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

COLGAN TRITLE ORTHODONTICS

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

Patient Information

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

Address _____
(Street / City / State / ZIP)

Birthdate _____ Age _____ E-mail _____
(MM/DD/YYYY)

Cell Phone _____ General Dentist _____ Last Visited _____

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

Responsible Party Information

Guardian

Name _____
(First / Middle / Last)

Address _____
(Street / City / State / ZIP)

Birthdate _____ Cell Phone _____ Social Security # _____
(MM/DD/YYYY)

Email _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____ Marital Status _____

Guardian

Name _____
(First / Middle / Last)

Address _____
(Street / City / State / ZIP)

Birthdate _____ Cell Phone _____ Social Security # _____
(MM/DD/YYYY)

Email _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____ Marital Status _____

General Information

School _____

Hobbies _____

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

(MORE ON OTHER SIDE)

PRIMARY DENTAL INSURANCE

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 Dental Claims Address _____ Insurance Phone No. _____

Do You have Dual Coverage? ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

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 Dental Claims Address _____ Insurance Phone No. _____

Do You have Dual Coverage? ☐ Yes ☐ No

Dental History

What would the patient like to change most about their 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 ☐ Jaw

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 _____

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

Have the patient's 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 ☐ 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 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 _____