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

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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.

Patient Information

Name _____ (Last) _____ (First) _____ (MIddle) Sex _____

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) General Dentist _____ Last Visited _____

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

Parent's Information

Father

Name _____ (Last) _____ (First) _____ (MIddle) 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 _____

Relationship to Patient _____

Mother

Name _____ (Last) _____ (First) _____ (MIddle) 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 _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Employer _____

Policy Owner's Date of Birth _____

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

Insurance Co. Address _____ Insurance Phone No. _____

Do You have Dual Coverage? ☐ Yes ☐ 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. _____

General Information

School _____ Brothers/Sisters (include ages) _____

Hobbies _____

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

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

Has the patient ever been evaluated for orthodontic treatment? _____

Has the patient 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 Do you like your smile? ☐ Yes ☐ No

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

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

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

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 _____