Coghlan
ORTHODONTICS, P.C.

J. Kevin Coghlan
D.D.S., M.S.D.

Orthodontics for Children & Adults

Welcome to Our Office!

PATIENT INFORMATION: PATIENTS UNDER 18 YEARS OF AGE

Today's Date:

Patient's Name: First Middle Initial Last Gender: (M) (F) Nickname:

Address: City: State: Zip:

D.O.B.(MM/DD/YYYY): Age: Phone: (Home) (Cell)

School: Grade: Sports/Hobbies:

Names and Ages of Siblings:

How did you hear about us?

RESPONSIBLE PARTY INFORMATION

Name (Primary):

Relationship to Patient:

Address:

City: State: Zip:

D.O.B. (MM/DD/YYYY) Social Security #:

Phone: (Home) (Cell)

(Work) Email:

Employer:

Occupation:

Marital Status: Spouse's Name:

Name (Secondary):

Relationship to Patient:

Address:

City: State: Zip:

D.O.B. (MM/DD/YYYY) Social Security #:

Phone: (Home) (Cell)

(Work) Email:

Employer:

Occupation:

Marital Status: Spouse's Name:

RESPONSIBLE PARTY INSURANCE INFORMATION

Policy Holder's Name (Primary) #:

Policy Holder's Social Security #:

Member ID #:

Insurance Company:

Insurance Address:

Insurance Company Phone #:

Policy Holder's Name (Secondary):

Policy Holder's Social Security #:

Member ID #:

Insurance Company:

Insurance Address:

Insurance Company Phone #:

Name of General Dentist: Date of Last Visit:

DENTAL HISTORY

YES	NO	
❑	❑	Has patient had any recent x-rays?
❑	❑	Is the patient presently in any dental treatment?
❑	❑	Has the patient ever experienced any unfavorable reaction to dentistry?
❑	❑	Has the patient ever lost or chipped any teeth?
❑	❑	Have there ever been any injuries to face, mouth, or teeth?
❑	❑	Is any part of the patient's mouth sensitive to temperature or pressure? Where?
❑	❑	Do his/her gums bleed when brushing?
❑	❑	Does the patient have any type of thumb or tongue habit?
❑	❑	Do his/her teeth or jaws ever feel uncomfortable first thing in the morning?
❑	❑	Does the patient experience jaw clicking or popping?
❑	❑	Does the patient clench or grind his/her teeth during the day?
❑	❑	Does the patient experience "tension" headaches?
❑	❑	Has the patient ever experienced chronic ringing in the ears?
❑	❑	Does the patient need extra help with instructions?

MEDICAL HISTORY

Physician: Date of Last Visit:

Address: Phone:

YES	NO	
❑	❑	Is the patient allergic to any medications?
❑	❑	Has the patient had any operations?
❑	❑	Has the patient ever been involved in a serious accident?
❑	❑	Has the patient seen a physician in the last 12 months? Why?
❑	❑	Does the patient have a Latex allergy?
❑	❑	Is the patient currently taking any medications? Please list:

Growth has a strong influence on the success of orthodontic treatment.

What is the height of patient's parents? Mom: Dad:

Is Patient Adopted? YES ❑ NO ❑

Is it likely that your child will be an early or a late maturer?

Female Patients: Has menstruation started: Date of onset:

Please check any of the following conditions that apply to the patient now, or in the past:

- ❑ Abnormal bleeding/hemophilia
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma or Hayfever
- ❑ Bone Disorders
- ❑ Cancer / Tumor
- ❑ Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Gastrointestinal Disorders
- ❑ Heart Problems
- ❑ Heart Murmur
- ❑ Hepatitis/Liver Problems
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Nervous Disorders
- ❑ Pneumonia
- ❑ Pregnancy
- ❑ Prolonged Bleeding
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Snoring / Noisy Breathing
- ❑ Sleep Apnea
- ❑ Excessive Daytime Sleepiness
- ❑ Restless Sleeper
- ❑ Bed wetting
- ❑ Teeth Grinding During Sleep
- ❑ Night Terrors / Sweating
- ❑ Mouth Breathing
- ❑ Other

Are there any other medical conditions that we have not discussed that you feel we should be aware of?

ORTHODONTIC GOALS

What are the concerns about the patient's teeth:

YES	NO	
❑	❑	Has the patient ever seen an orthodontist? If yes, who and when?
❑	❑	Has anyone in the family received orthodontic treatment? How did they feel about the result?
		Orthodontic treatment can, to some extent, alter facial appearance.
❑	❑	Would you prefer that facial appearance NOT be discussed in front of your child?
❑	❑	Is the patient sensitive or self-conscious about his/her teeth?
❑	❑	Is the patient sensitive or self-conscious about his/her facial appearance?
		What is the patient's attitude toward receiving orthodontic treatment?

I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment; I understand that where appropriate credit bureau reports may be obtained. By signing this form I consent to J. Kevin Coghlan, DDS, MSD performing an examination for this patient and agree that I have authorization to consent to an examination on behalf of this minor patient.

Responsible Party Signature: Date:

Coghlan
ORTHODONTICS, P.C.

J. Kevin Coghlan
D.D.S., M.S.D.

Orthodontics for Children & Adults

Welcome to Our Office!

PATIENT INFORMATION

Today's Date: _____

Patient's Name: First _____ Middle Initial _____ Last _____ Gender: (M) (F) Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ D.O.B (MM/DD/YYY): _____ Age: _____

Phone:(Home) _____ (Cell) _____ (Work) _____ Email: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name(Primary) : _____

Relationship to Patient: _____ D.O.B (MM/DD/YYY): _____

Address: _____

Phone: _____ Cell: _____

Email: _____

Employer: _____

Insurance Company: _____

Policy Holder's Social Security # : _____

Member ID #: _____

Insurance Company Phone #: _____

Policy Holder's Name (Secondary): _____

Relationship to Patient: _____ D.O.B (MM/DD/YYY): _____

Address: _____

Phone: _____ Cell: _____

Email: _____

Employer: _____

Insurance Company: _____

Policy Holder's Social Security # : _____

Member ID #: _____

Insurance Company Phone #: _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

DENTAL HISTORY

Name of General Dentist Date of Last Visit:

YES	NO	
❑	❑	Has the patient had any recent x-rays?
❑	❑	Is the patient presently in any dental treatment?
❑	❑	Has the patient ever experienced any unfavorable reaction to dentistry?
❑	❑	Has the patient ever lost or chipped any teeth?
❑	❑	Have there ever been any injuries to face, mouth, or teeth?
❑	❑	Is any part of the patient's mouth sensitive to temperature or pressure? Where?
❑	❑	Do his/her gums bleed when brushing?
❑	❑	Does the patient have any type of thumb or tongue habit?
❑	❑	Do his/her teeth or jaws ever feel uncomfortable first thing in the morning?
❑	❑	Does the patient experience jaw clicking or popping?
❑	❑	Does the patient clench or grind his/her teeth during the day?
❑	❑	Does the patient experience "tension" headaches?
❑	❑	Has the patient ever experienced chronic ringing in the ears?
❑	❑	Does the patient need extra help with instructions?

MEDICAL HISTORY

Physician: Date of Last Visit:

Address: Phone:

YES	NO	
❑	❑	Is the patient allergic to any medication?
❑	❑	Has the patient had any operations?
❑	❑	Has the patient ever been involved in a serious accident?
❑	❑	Has the patient seen a physician in the last 12 months? Why?
❑	❑	Does the patient have a Latex allergy?
❑	❑	Is the patient currently taking any medications? Please list:

Please check any of the following conditions that apply to the patient now, or in the past:

- ❑ Abnormal bleeding/hemophilia
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma or Hayfever
- ❑ Bone Disorders
- ❑ Cancer / Tumor
- ❑ Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Gastrointestinal Disorders
- ❑ Heart Problems
- ❑ Heart Murmur
- ❑ Hepatitis/Liver Problems
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Nervous Disorders
- ❑ Pneumonia
- ❑ Pregnancy
- ❑ Prolonged Bleeding
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Snoring / Noisy Breathing
- ❑ Sleep Apnea
- ❑ Excessive Daytime Sleepiness
- ❑ Teeth Grinding During Sleep
- ❑ Restless Sleep
- ❑ Mouth Breathing
- ❑ Other

Are there any other medical conditions that we have not discussed that you feel we should be aware of?

ORTHODONTIC GOALS

What are the concerns about the patient's teeth:

What is the patient's attitude toward receiving orthodontic treatment?

Has anyone in the family received orthodontic treatment? **YES** ❑ **NO** ❑

If Yes How did they feel about the result?

Orthodontic treatment can, to some extent, alter facial appearance.

Are you satisfied with your facial appearance? **YES** ❑ **NO** ❑ If not, what would you like to change about it?

Has the patient ever seen an orthodontist? **YES** ❑ **NO** ❑ If yes, who and when?

I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment; I understand that where appropriate credit bureau reports may be obtained.

Patient Signature: Date: