

John E. Murphy D.D.S., M.S.

Patient Information

Date	_____	M	_____	F	_____	Age	_____	Grade	_____
Patient name	_____							Birthdate	_____
	<small>Last</small>		<small>First</small>			<small>Middle Initial</small>			
Address	_____								
	<small>Street</small>			<small>City</small>				<small>Zip</small>	
E-Mail (home)	_____		Home Phone (____)	_____		Social Security #	_____		
If patient is a minor, give parent's or guardian's name _____									
Whom may we thank for referring you to our office? _____									
Who is your general Dentist? _____					Who is your general Physician? _____				

Responsible Party Information

Parent's Name	_____					Marital Status	_____		
	<small>Last</small>		<small>First</small>	<small>Middle</small>	<small>Suffix</small>				
Address	_____						Zip	_____	
	<small>Street</small>			<small>City</small>					
How long at this address?	_____		E-Mail	_____		Work phone(____)	_____		
Previous Address (If less than 3 years) _____									
Social Security #	_____		Birthdate	_____		Relationship to Patient	_____		
Employer	_____			Occupation	_____		No. years employed	_____	
Spouse's Name	_____					Relationship to Patient	_____		
	<small>Last</small>		<small>First</small>	<small>Middle</small>					
Employer	_____			Occupation	_____		No. years employed	_____	
Social Security #	_____		Birthdate	_____		Work Phone	_____		

Dental Insurance Information

Policy Holder's Name	_____				Social Security #	_____			
Insurance Co.	_____			Group No./ID No.	_____		Local No.	_____	
Insurance Co. Address _____									
Insurance Co. Phone No. _____									
Do you have dual coverage? No _____ Yes _____ (if yes fill in secondary coverage below)									
Policy Holder's Name	_____				Social Security #	_____			
Insurance Company	_____			Group No./ID No.	_____		Local No.	_____	
Insurance Co. Address _____									

Emergency Information

Name of nearest relative not living with you _____									
Complete address _____									
	<small>Street</small>			<small>City</small>				<small>Zip</small>	
Phone (____)	_____			Relationship to Patient	_____				

I understand that where appropriate, credit bureau reports may be obtained

MEDICAL HISTORY

Is the patient in good health? Yes No Reason _____
Any major or unusual illnesses? Yes No Explain _____
Currently under physician's care? Yes No Reason _____
Currently taking medication? Yes No List _____
Allergies /Drug Sensitivity (food, metals, medication, etc.) Yes No List _____

Please Check if Patient Has or Had Any of the Following:

Anemia Heart Problems Frequent colds or Flu
Blood Disorders Tuberculosis Tonsillitis
Prolonged Bleeding Diabetes Adenitis
Hepatitis Endocrine Problems Tonsils Removed: Age _____
HIV Bone Disorders adenoids Removed: Age _____
Jaundice Epilepsy/Seizures Asthma
Rheumatic Fever Herpes Adenitis
Dental Bridge/False Teeth Ear/Hearing Problems Mouth breathing: While Awake?
While Asleep?

Growth Information for Patients Under 16 Years of Age

Father's Height: _____ Mother's Height: _____ Adopted? Yes No
Patient Resembles: Neither Parent Mother Father
Girls: Has she started menstruation? Yes No When? _____ Height _____ Weight _____
Boys: Has his voice changed? Yes No When? _____ Height _____ Weight _____
Name and Ages of Patients Brothers and Sisters: _____
Have siblings had any Orthodontic Treatment? Yes No

DENTAL HISTORY

YES NO

Has the patient had any severe head or face injuries? Explain _____
Has the patient had a history of thumb sucking or finger sucking? Stopped? _____
Does the patient play any musical (wind) instruments? What? _____
Has the patient consulted an orthodontist previously? Who? _____
Has the patient had any previous orthodontic treatment? When? _____
Has the patient experienced any dental trauma? When? _____

IS THERE A HISTORY OF?

Clenching Teeth Headaches (more than normal) Jaw Joint Popping
Grinding Teeth Ringing in the Ears Jaw Joint Soreness
Muscular Soreness around Head and Neck Jaw Joint Clicking

Is there any other information that may be helpful? _____
Why are you seeking orthodontic consultation? _____
Personal interests (sports, hobbies/ activities): _____

Signature (Parent's if child is a minor) _____ Date _____

Updates (dates & initials) _____