Saylor & Murphy™
orthodontics

We would like to welcome you and your child to our office. Our mission is to enhance the lives of our patients and their families by providing exceptional orthodontic care with excellent customer service in a safe and inviting atmosphere.

Tell Us About Your Child

☐ Male ☐ Female

Childs Name: _____
Last First Mi

Nickname: _____ SS#: _____

Child's Birthdate: ____/____/____ Child's Age: _____

Child's Home #: (_____) _____

Child's Home Address: _____
Apt/Condo#

_____
City State Zip

How long at this address: _____

Previous Address (*If less then three years*): _____

_____
City State Zip

Whom may we thank for referring you? _____

General Dentist: _____ Last Visit: _____

Emergency

Name: _____ Phone: (____) _____

Address: _____

_____
City State Zip

Nearest Relative not living with you: _____

Phone: (____) _____ Relation to Patient: _____

Address: _____

_____
City State Zip

Responsible Party

☐ **Mother's Information** ☐ **Step Mother** ☐ **Guardian**

Name: _____ Birthdate: ___/___/___

Do you have legal custody of this child? ☐ Yes ☐ No

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Cell #: (____) _____

SS #: _____ E-mail: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

☐ **Father's Information** ☐ **Step Father** ☐ **Guardian**

Name: _____ Birthdate: ___/___/___

Do you have legal custody of this child? ☐ Yes ☐ No

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Cell #: (____) _____

SS #: _____ E-mail: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

Parent's Martial Status: ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated

Dental Insurance

Orthodontic Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Secondary Insurance

Orthodontic Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

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

Continued on Back

What are your specific concerns regarding your child's teeth?

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? _____

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD) ? ☐ Yes ☐ No

Does your child brush his/her teeth twice daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Is your child currently under the care of a physician? ☐ Yes ☐ No

Phone #: (____)_____ Date of Last Visit: _____

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all medications that your child is currently taking:

_____

Please list any allergies: _____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Has your child ever had any of the following?

Y	N	Abnormal Bleeding	Y	N	Disabilities
Y	N	ADD/ ADHD	Y	N	Fainting
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Allergic to Latex / Metals	Y	N	Heart Murmur
Y	N	Allergic to Plastics	Y	N	Hemophilia
Y	N	Any Hospital Stays	Y	N	HIV+ / AIDS
Y	N	Any Operations	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Seizures
Y	N	Convulsions / Epilepsy	Y	N	Sickle Cell Disease / Traits
Y	N	Dental Phobia	Y	N	Tuberculosis (TB)
Y	N	Diabetes			

If you circled yes to any of these please explain further if necessary:

_____

_____

_____

Does / did your child have any of the following habits?

Y	N	Clenching / Grinding Teeth	Y	N	Speech Problems
Y	N	Lip Sucking / Biting	Y	N	Thumb / Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting			

Growth information for Patients Under 16 Years of Age

Fathers Height: _____ Mothers 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

I understand the information that I have given today is correct and to the best of my knowledge. I also understand that is information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary services that the patient may need during diagnosis and treatment.

_____ _____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____

_____

Signature Date