MURPHY
orthodontics

Patient Information

Patient Name _____Age (_____) Birthdate _____

Nickname/ likes to be called_____ School:_____ Sex: M F

If patient is a minor, name of person(s) with patient at exam _____Relationship_____

Has Patient or family member been to our office before regarding orthodontics? Y N If yes, who?_____

Has Patient seen another Orthodontist ?_____ If yes, who? _____When?_____

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

Emergency Contact Information:
Name of nearest relative not living with you:_____Relationship_____

Address_____ Contact Phone #_____

Medical/Dental History

Family Physician_____
Is patient under the care of a Physician?_____ If Yes, for what?_____
List medication being taken_____ For what? _____
List allergies to any medications_____
Has the patient been diagnosed or treated for any of the following? (Circle all that apply)

Rheumatic Fever	Blood Disorders	Lung Disorders	Bone Disorders
Heart Disease	Anemia	Tuberculosis	Arthritis
Abnormal Blood Pressure	Hepatitis	Asthma	Diabetes
Heart Murmur	AIDS/HIV Pos.	Seizures	Other _____

Dentist_____ Address_____
Phone_____ Last Visit _____ Any dental work left to be done? Yes/No If Yes, What?_____

Does the patient require PRE-medication before dental procedures?	YES	NO	
Has the patient ever taken medication for their bones?	YES	NO	
Does the patient have a latex allergy? Nickel allergy?	YES	NO	
Does the patient have a persistent thumb or finger habit?	YES	NO	
Is the patient a mouth-breather (versus breathing primarily through the nose)?	YES	NO	
Does the patient have difficulty breathing through their nose?	YES	NO	
Does the patient have sleep apnea?	YES	NO	
Has the patient ever had their tonsils and/or adenoids removed?	YES	NO	
Does the patient vomit, gag, or faint easily?	YES	NO	
Does the patient experience frequent headaches or neck aches?	YES	NO	SOMETIMES
Does the patient grind or clench their teeth?	YES	NO	SOMETIMES
Has the patient experienced any pain, popping, or locking of the jaw?	YES	NO	SOMETIMES
Has the patient ever experienced trauma to their jaw or teeth?	YES	NO	WHEN ?_____
Has the patient been treated or recommended treatment for periodontal disease?	YES	NO	WHEN ?_____
Have we treated any other family members? If yes, who?	YES	NO	WHO ?_____
Is Patient/Parent aware that appointments will infringe on work/school?	YES	NO	

I understand 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 medical or dental status.

_____ _____
Signature Date

_____ _____
Doctor Signature Date

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Confidential Responsible Party Information

Responsible Party Name:_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How Long at this address?_____ Hm Phone _____Wk Phone_____ Cell_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____Birthdate _____Relationship to Patient_____

Employer_____Occupation_____No. Yrs Employed_____

Spouse Name_____ Relationship to Patient_____
Last First Middle

Employer_____Occupation_____No. Yrs Employed_____

Social Security # _____ Birthdate _____ Hm Phone_____Wk Phone _____

Confidential Patient Information

Patient Name_____Birthdate_____
First Last Middle

Address (if different)_____
Street City State Zip

Hm Phone (if different) _____ Social Security #_____

Patient Email _____**Responsible Party Email**_____

Insurance Information

Primary Insurance

Policy Holder's Name_____ ID#_____

Employer Plan _____ Group #_____ Local Union _____

Insurance Company_____ Phone_____

Billing Claims Address_____

Secondary Insurance

Policy Holder's Name_____ ID#_____

Employer Plan _____ Group #_____ Local Union _____

Insurance Company_____ Phone_____

Billing Claims Address_____

**** I understand that where appropriate, credit bureau reports may be obtained by the office of Dr. C. Chris Murphy***

Signature (Parent's signature if minor)_____Date_____

OFFICE LOCATIONS

SCOTTSDALE Location – 4910 E Greenway Rd #1, Scottsdale, Az 85254 (Phone 602-482-0022)

- We are located off of Tatum Blvd. approximately 3 miles SOUTH of the 101 Freeway
- We are on Greenway Rd. about 200 yards EAST of Tatum Blvd
- We are the tan dental office building on the NORTH side of the street in between a daycare and a church

GOODYEAR Location – 13210 W. Van Buren Ave #106, Goodyear, Az 85338 (Phone 623-932-9212)

- We are located off Dysart Rd. approximately 1 mile SOUTH of the I-10 Freeway
- We are on Van Buren St. about 200 yards WEST of Dysart
- We are in the tan office building on the NORTH side of the street

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Directions between offices

GOODYEAR TO SCOTTSDALE

Route # 1

- Take I-10 EAST to SR-51
- Take SR-51 NORTH about 11 miles to Greenway
- Turn right (EAST) on Greenway
- Proceed about 2 miles
- We are on Greenway Rd. about 200 yards just EAST of Tatum Blvd
- We are the tan dental office building on the NORTH side of the street in between a daycare and a church

Alternate route # 2

- Take I-10 EAST to the 101 freeway
- Take the 101 NORTH and continue about 26 miles to Tatum Blvd exit
- Turn right (SOUTH) on Tatum
- Proceed about 3 miles to Greenway
- Turn left (EAST) on Greenway and proceed about 200 yards
- We are the tan dental office building on the NORTH side of the street in between a daycare and a church

SCOTTSDALE TO GOODYEAR

Route # 1

- Take the SR-51 SOUTH about 11 miles to the I-10
- Take the I-10 WEST about 18 miles to Dysart Rd
- Turn left (SOUTH) on Dysart and proceed 1 mile to Van Buren
- Turn right (WEST) on Van Buren and proceed about 200 yards
- We are in the tan office building on the NORTH side of the street

Alternate route # 2

- Take the 101 WEST about 26 miles to the I-10 freeway
- Take the I-10 WEST about 4 miles to Dysart Rd
- Turn left (SOUTH) on Dysart and proceed 1 mile to Van Buren
- Turn right (WEST) on Van Buren and proceed about 200 yards
- We are in the tan office building on the NORTH side of the street

WELCOME TO OUR OFFICE

We would love to get to know you better!
If you would, please take a moment
to answer the questions below.
Thanks!!!

What nickname do you like to be called? _____

Where are you from originally?_____

Have you lived anywhere else? Where?_____

Do you have children?_____

If yes, what are their names and ages?_____

_____

What are your hobbies?_____

Names of family or friends that come to our office_____

Is there anything special you'd like for us to know?_____

_____