



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 _____



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 _____

Orthodontic Insurance Information

Primary Dental Insurance
Policy Holder's Name _____ ID# or SS# _____
Employer _____ Group # _____ Birthdate _____
Insurance Company _____ Phone _____
Billing Claims Address _____

Secondary Dental Insurance
Policy Holder's Name _____ ID# or SS# _____
Employer _____ Group # _____ Birthdate _____
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

CITY NORTH Location on High Street

5355 E High St. Suite 105, Phoenix, AZ 85054
Phone 602-482-0022

- We are located off of Deer Valley Dr. and 54th Street. approximately 1 mile NORTH of the 101 Freeway and just EAST of Desert Ridge Marketplace
- We are on High Street. (just EAST of **Kona Grill**)
- We are the between **Aspire Salon** and **Me The Artist**

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

Directions between offices

GOODYEAR TO SCOTTSDALE

Route # 1

- Take I-10 EAST to SR-51
- Take SR-51 NORTH to the 101 EAST
- Exit 101 (EAST)
- Proceed 101 EAST to Tatum Exit
- Exit on Tatum turn Left (NORTH)
- North on Tatum, turn right on Deer Valley to 53rd St
- Turn right on 53rd St and proceed about 1 block to HIGH street turn left
- We are on the SOUTH side of High Street by Aspire Salon

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 left /Exit the 101 on Tatum (NORTH)
- Proceed NORTH to Deer Valley Dr
- Turn right (EAST) on Deer Valley and proceed about a ½ mile to 53rd Street
- Turn RIGHT on 53rd St proceed about 200 yards to High Street and turn LEFT proceed about 200 yards we are on the right

CITY NORTH TO GOODYEAR

Route # 1

- Take the 101 West to 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? _____
