Scott B. Murray, DMD

ORTHODONTICS

Diplomate, American Board of Orthodontics

Date _____ **Confidential Patient Information** A B C

Patient's Name _____ ☐ M / ☐ F
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Confidential Responsible Party/Adult Patient Information

Name _____ **Marital Status** _____
Last First Middle

Residence _____ ☐ **Own** ☐ **Rent**
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 years) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ **Birthdate** _____ Relationship to Patient _____

Employer _____ **Occupation** _____ **No. Years Employed** _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ **Birthdate** _____ Email _____

Employer _____ **Occupation** _____ **No. Years Employed** _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports will be obtained.

Patient / Parent / Guardian Signature _____ Date _____

Updates (date & initial) _____

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Do you have Dental Insurance? Yes ☐ No ☐ If yes please provide information.

Insurance Information

Policy Holder's Name _____ Soc. Sec. # _____

Policy Holder's Employed by _____

Insurance Company _____ Group No. _____ Policy Holder's Birthdate _____

Insurance Co. Address _____ Insurance Co. Phone _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to **Scott B. Murray, DMD.**

X _____

Subscriber Signature of 1st Insurance **Date**

Do you have dual coverage? Yes ☐ No ☐ If yes fill out section B.

Section B Insurance Information

Policy Holder's Name _____ Soc. Sec. # _____

Policy Holder's Employed by _____

Insurance Company _____ Group No. _____ Policy Holder's Birthdate _____

Insurance Co. Address _____ Insurance Co. Phone _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to **Scott B. Murray, DMD.**

X _____

Subscriber Signature of 2nd Insurance **Date**

Patient History

Patient's Name: _____

What is your chief concern for us at this visit? _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____) _____Date of last visit: _____

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen?
Also known as Redux or Pondimin. ☐ Yes ☐ No

If so, when?_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding/Hemophilia	Y N Herpes/Fever Blisters
Y N AIDS	Y N High Blood Pressure
Y N Alcohol/Drug Abuse	Y N HIV
Y N Anemia	Y N Hospitalized for Any Reason
Y N Arthritis	Y N Kidney Problems
Y N Artificial Bones/Joints/Valves	Y N Liver Disease
Y N Asthma	Y N Low Blood Pressure
Y N Blood Transfusion	Y N Lupus
Y N Cancer/Chemotherapy	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease/Traits
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack/Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Asprin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to:_____

_____

Dental History

Name of patient's **dentist:** _____

Date of last dental exam:_____

Has another family member received orthodontic treatment in our office?

Y N Who? _____

Have you ever had or been evaluated for orthodontic treatment? Y N

Y N Chipped or injured permanent teeth
Y N Teeth sensitive to hot or cold
Y N Jaw fractures, cyst, mouth infections
Y N Previous root canal therapy
Y N Bleeding gums or bad taste/mouth odor
Y N Other periodontal (gum) problems
Y N Problems with food trapped between teeth
Y N Frequent canker sores or cold sores
Y N Mouth breathing habit or snoring troubles
Y N Abnormal swallowing (tongue thrust)
Y N Has there been a negative dental experience?
Y N Would you consider the patient's diet high in sweets/sugars?
Y N History of missing or extra teeth
Y N Have any permanent teeth been removed?
Y N Have wisdom teeth been removed?
Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Previous orthodontic treatment or retainer
Y N Previous periodontal (gum) treatment
Y N Numerous fillings
Y N Damaged restorations or fillings
Y N Thumb or finger habit as a child
Y N Loose or shifting teeth
Y N Is all dental work completed at this time?

Patient's deciduous ("baby") teeth came in:
☐ EARLY ☐ AVERAGE ☐ LATE

Patient's deciduous ("baby") teeth were lost:
☐ EARLY ☐ AVERAGE ☐ LATE

Patient's mouth most resembles:
☐ MOTHER ☐ FATHER ☐ BOTH ☐ NEITHER

TMJ (Jaw Joint) History

Y N Has the patient had a TMJ screening?
Y N Does the patient have a history of jaw joint problems?
Y N Has the patient been treated for "TMJ"?
Y N Does his/her bite feel uncomfortable or unusual?
Y N Does the patient grind his/her teeth?
Y N Does the patient clench his/her teeth?
Y N Has the patient's jaw ever locked?
Y N Does the patient have pain in his/her jaw joint?
Y N Does the patient experience soreness in the muscles of his/her face or around ears?
Y N Does the patient notice clicking or popping in his/her jaw joint?
Y N Does the patient have difficulty chewing or opening his/her mouth?

**I certify that I read and understand the above. I acknowledge that I have completed this from to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of my child's form. If there are any changes later to this history record or medical or dental status, I will inform the practice.

Signature of Patient/Parent/Guardian	Date	Scott B. Murray, DMD	Date
Update Signature	Date	Dr.'s Update Signature	Date
Update Signature	Date	Dr.'s Update Signature	Date