



MURRAY
ORTHODONTICS

**PATIENT MEDICAL/DENTAL HISTORY
CHILD FORM**

Today's Date: _____ Patient's Dentist: _____

Patient's Name: _____ Age: _____ Birthdate: _____ Sex: M F

Prefers to be called: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ School: _____ Grade: _____ Hobbies: _____

BILLING PARTY INFORMATION

Father's Name: _____ Cell Phone: _____ Home Phone: _____

E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

If different than patient's address

Father's Employer: _____ Occupation: _____ Work Phone: _____

SS#: _____ Insurance Company: _____

ID#: _____ Group #: _____ Father's DOB: _____

Primary Benefit Secondary Benefit Yes No Ortho Benefits If Yes, Benefit Amount: \$ _____

Mother's Name: _____ Cell Phone: _____ Home Phone: _____

E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

If different than patient's address

Mother's Employer: _____ Occupation: _____ Work Phone: _____

SS#: _____ Insurance Company: _____

ID #: _____ Group #: _____ Mother's DOB: _____

Primary Benefit Secondary Benefit Yes No Ortho Benefits If Yes, Benefit Amount: \$ _____

Parents' Marital Status: Married Single Divorced Separated Widowed

Patient Siblings:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Anchorage East Office:
2211 E. N. Lights Blvd., Ste. 207
Anchorage, Alaska 99508
Fax: (907) 274-4925

Anchorage South Office:
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Anchorage, Alaska 99515
Fax: (907) 345-2900

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www.murrayorthodontics.com
info@murrayorthodontics.com





DENTAL HISTORY

Date of Last Visit:	
1. Have there been any injuries to the face, mouth or teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Has the patient had or presently have any of the following habits?	<input type="checkbox"/> Thumb or Finger sucking <input type="checkbox"/> Lip Biting <input type="checkbox"/> Snoring <input type="checkbox"/> Grinding of teeth at night <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> None
3. Has the patient been informed of any missing or extra permanent teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Is the patient aware of sores, lumps or irritated areas in the mouth?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Has the patient ever been treated for: <input type="checkbox"/> Bad Bite <input type="checkbox"/> TMJ <input type="checkbox"/> Periodontal disease <input type="checkbox"/> No If so, who was the treating doctor?	
7. Does the patient have any speech problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Is the patient frightened or anxious about orthodontic treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. What aspect of dental treatment is the patient most concerned with?	<input type="checkbox"/> Quality <input type="checkbox"/> Cost <input type="checkbox"/> Discomfort <input type="checkbox"/> Time
10. Reason for Consultation (Chief Concern):	
11. Has there ever been any orthodontic treatment for any other member of the family? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you satisfied with the result? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Mother treated by Dr. _____ <input type="checkbox"/> Father treated by Dr. _____	
<input type="checkbox"/> Sister treated by Dr. _____ <input type="checkbox"/> Brother treated by Dr. _____	

MEDICAL HISTORY

1. Is the patient's general health good at this time	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What is the name of the family physician?	Date of last physical
3. Is the patient under the care of a physician at this time? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the patient taking any medication? Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the patient had tonsils and/or adenoids removed? Age:	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has the patient ever had a serious illness or been hospitalized? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the patient have any special problems not listed? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. What is the patient's approximate height?	Weight?
11. Has the patient shown signs of increased growth recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has the patient reached puberty? Girls – started menstruating? Boys – voice changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Father's present height:	Mother's present height:
14. Older brother's height:	Older sister's height:

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DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ADD	
<input type="checkbox"/>	<input type="checkbox"/>	ENDOCARDITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE	
<input type="checkbox"/>	<input type="checkbox"/>	HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	
<input type="checkbox"/>	<input type="checkbox"/>	HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC TREATMENT	
<input type="checkbox"/>	<input type="checkbox"/>	HEART ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION	
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK (CORONARY	<input type="checkbox"/>	<input type="checkbox"/>	HERPES (ORAL-COLD SORES)	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES	
<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EARACHES
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JAW CLICKING
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY; Date _____	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO METAL
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JAW PAIN
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS
<input type="checkbox"/>	<input type="checkbox"/>	PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	X-Ray/Radiation (cancer) therapy	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR H.I.V. POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA				
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING SPELLS				

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I understand that when appropriate a credit report may be obtained.

 _____
Signature of parent or guardian

Date

Signature of dentist


Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign this form to verify you have received the attached HIPPA Notice Form.
You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Parent or Guardian Name

Print Patient Name

 _____
Guardian Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- Emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

NOTES: _____

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