BRIAN A. McMURTRY, D.D.S., F.A.G.D.

Fellow of the Academy of General Dentistry

Patient Information

Patient Name: _____ Today's Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security#:_____ Birth Date:_____

Phone (Cell): _____ Phone (Work): _____

Phone (Home): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ Occupation: _____

Referral Information

Who referred you to our practice: ☐ Family Physician / ENT / Dentist ☐ Lactation Consultant ☐ Bodyworker

☐ Another Patient: _____

☐ Google/Yahoo/Bing. What was search term? _____

☐ New Homeowner Brochure ☐ School Homework Folder ☐ Local Sports ☐ Saw our sign driving by

☐ Facebook: Tongue Tie Babies Support Group ☐ Facebook: Tongue and Lip Tie Support of NC/SC

☐ Facebook: Tongue Tie Adult Support Group ☐ Facebook: Greater Charlotte Natural Birth and Parenting

☐ Facebook: Other: _____

☐ Other: _____

Consent for Services / Responsible Party Information

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
- **I understand I am responsible for any amount not paid by my insurance carrier.**
- I understand that the fee estimate listed for this dental care is valid for a period of six months from the date of the patient examination.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my account.
- I consent and permit Dr. McMurtry to diagnose any and all dental conditions I may have.
- By my scheduling subsequent treatment appointments, I consent and give permission to Dr. McMurtry and his staff to treat the dental conditions previously diagnosed.

I have read the above conditions of treatment and payment and agree to their content.

✶ _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Patient's Name _____

Medical History

Have you ever had any of the following? Please check those that apply:

☐ HIV or AIDS	☐ Latex Allergy	☐ Heart Disease	☐ ADD / ADHD	☐ Tumors or Growths
☐ Hepatitis A, B, C	☐ Pacemaker	☐ High Blood Pressure	☐ Mental or Nervous Disorders	☐ Anorexia or Bulimia
☐ Asthma w/ Inhaler use	☐ Stroke	☐ Anemia	☐ Head Injuries	☐ Arthritis / Gout
☐ Bleeding Problems	☐ Epilepsy or Seizures	☐ Blood Disease	☐ Glaucoma	☐ Excessive Thirst
☐ Dizziness / Fainting	☐ Hypoglycemia	☐ Untreated Chest pain	☐ Thyroid Problem	☐ Addiction – Drug / Alcohol
☐ Antibiotic Pre-med : Amoxicillin / Clindamycin / Other		☐ Heart Murmur	☐ Lung Disease or Problems	☐ Long-term steroid medicine
☐ Blood Thinner – Aspirin / Coumadin / Other		☐ Mitral Valve Prolapse	☐ Tuberculosis	☐ Venereal Disease
☐ Diabetes: Type ___ Last BSL? _____ Last A1C? _____		☐ Congenital Heart Lesion	☐ Stomach Ulcers / GERD	☐ Cold Sores / Fever Blisters
☐ Pregnant : due date _____		☐ Artificial Joints or Valves	☐ Kidney or Liver Disease	☐ Frequent Headaches
☐ Cancer : Location? _____		☐ Rheumatic or Scarlet Fever	☐ Jaundice	☐ Pain in Jaw Joint
When Diagnosed? _____ Chemo / Radiation? (circle) Free & Clear? ☐ Yes ☐ No			☐ Other : _____	

☐ Yes ☐ No Have you ever been told you needed to take antibiotic premedication prior to your dental appointment?

☐ Yes ☐ No Do you currently smoke cigarettes or cigars? (please circle)
If yes, for how many years? _____. How much per day? _____ = _____ packs per day.

☐ Yes ☐ No Have you ever smoked cigarettes or cigars in the past? (please circle)
If yes, for how many years? _____. How much per day? _____. When quit? _____

☐ Yes ☐ No Use(d) smokeless tobacco? How much per day? _____. how many years? _____

☐ Yes ☐ No Have you had an unusual reaction to "Novocain" or other local anesthetic?

☐ Yes ☐ No Do you have any allergies to any medications?
If yes, please list _____

☐ Yes ☐ No Are you taking birth control pills or other hormones?

☐ Yes ☐ No Have you been treated by a physician or hospitalized in the past year?
If yes, please explain _____

☐ Yes ☐ No Have there been any changes in your general health in the past year?
If yes, please explain _____

☐ Yes ☐ No Do you snore?

☐ Yes ☐ No Do you get headaches or migraines on a regular basis? how often? _____

☐ Yes ☐ No Do you have any head, neck, or shoulder muscle tension? (circle)

☐ Yes ☐ No Do you have any speech issues? Lisps, slurred speech, tired speech after long day, vocal fatigue, etc..?

☐ Yes ☐ No Do you have TMJ or TMD?

☐ Yes ☐ No Do you have a "bad" gag reflex?

Name of Physician : _____ Phone:_____

Name of Cardiologist : _____ Phone:_____

Please list any Medications, Herbal Supplements, or Vitamins you are currently taking

Medication	For what condition are you taking this medication?	Medication	For what condition are you taking this medication?

If you are taking more than 10 medications, please continue on other side or supply medication list

Patient's Name _____

Dental History

What brings you here to see us today? _____

Date of last dental visit: _____ Reason for that visit: _____

Who was your former dentist?_____ _____ City/State: _____

☐ Yes ☐ No Did you see this dentist regularly? (every 6 months for cleanings or 3 months for perio cleanings)

☐ Yes ☐ Maybe ☐ No If diagnosed at risk for cavities today, would you be interested in discussing treatment options?

☐ Yes ☐ Maybe ☐ No If needed, are you willing to modify your dietary habits?

☐ Yes ☐ No Are you having any pain or discomfort at this time?
If yes, please explain where: _____

☐ Yes ☐ No Are you nervous about having dental treatment?
If yes, please explain:_____

☐ Yes ☐ No Do you brush your teeth at least two times per day with a soft bristled or electric toothbrush?

☐ Yes ☐ No Do you use a toothpaste with fluoride or xylitol?

☐ Yes ☐ No Do you floss at least 5 times per week? If no, how many times per week? _____ or per month?_____

☐ Yes ☐ No Have you ever been told you have "gum disease","pyrorrhea",or "gingivitis" or had a "deep cleaning"?

☐ Yes ☐ No Are you happy with the appearance of your teeth/gums/smile?
If not, please explain what you don't like_____

☐ Yes ☐ No Are you happy with the color of your gums?

☐ Yes ☐ No Are you interested in straightening your teeth without the use of braces (Invisalign)?

☐ Yes ☐ No Would you like to discuss how to make your teeth WHITE?

☐ Yes ☐ No Do you have bad breath?

☐ Yes ☐ No Do you have sensitive teeth? What makes them sensitive? _____

☐ Yes ☐ No Do you clench/grind your teeth?

☐ Yes ☐ No Do you wear a biteguard/nightguard?

☐ Yes ☐ No Do you want to hide mercury fillings when you smile?

☐ Yes ☐ No Do you have unattractive front caps, crowns, or bridgework

☐ Yes ☐ No Do you have chipped teeth that you want corrected?

☐ Yes ☐ No Do you have spaces between your teeth that you want corrected?

☐ Yes ☐ No Do you have overlapping or rotated teeth that you want corrected?

☐ Yes ☐ No Do you want to change the size/shape of your teeth?

☐ Yes ☐ No Do you want a more confident smile?

☐ Yes ☐ No Do you notice plaque build-up on your teeth between brushings?

☐ Yes ☐ No Do you feel like you have a dry mouth at any time of the day or night?

☐ Yes ☐ No Do you drink liquids other than water more than 2 times daily between meals?

☐ Yes ☐ No Do you snack daily between meals?

☐ Yes ☐ No Do you have oral appliances present?

☐ Yes ☐ No Do ANY of these other health concerns apply to you? (check all that apply)

☐ Frequent tobacco use ☐ Head/neck radiation therapy ☐ Other drug use ☐ Diabetes
☐ Acid reflux ☐ Bulimia ☐ Sjogren's Syndrome

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my medical or dental health, I will inform Dr. McMurtry at the next appointment.

✶ _____ _____ Date:_____

Patient Name (Printed) Signature of patient, parent or guardian

Doctor notes:_____

_____

_____

BRIAN A. McMURTRY, D. D. S., P.A.
10816 Black Dog Lane, Suite 100, Charlotte NC 28214

Acknowledgement of Receipt Of Notice of Privacy Practices

Available in-office and online at http://mivdental.com/privacy.html

Name: _____ Address : _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

✶ _____ _____

Signature Date

Release of Information Authorization for Family and Friends

Dr. McMurtry's office is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐Spouse	☐Family billing information ☐Medical
☐Parent (provide name)_____	☐Family Billing Information ☐Medical
☐Other (provide name) _____ _____	☐Financial ☐Medical as follows _____

Rights of the Patient. I understand that I can revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. McMurtry's office. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

✶ _____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____

Prepared By _____ Date: _____

Signature _____

BRIAN A. McMURTRY, DDS, FAGD
Fellow of the Academy of General Dentistry
Family & Cosmetic Dentistry

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Fax: (704) 392-3893
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Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payments are expected at the time services are rendered. We accept cash, checks (under $500.00), debit cards, Visa, Mastercard, and American Express credit cards. Returned checks are subject to a Non-sufficient funds fee issued by your bank AND our bank.

Check payment over $500 is only accepted for pre-payment of treatment and for patients with an established payment history.
Optional Payment Terms:

1. **Bookkeeping Discount**: If you have a treatment plan totaling $4000 or more, a 5% discount will be applied if the treatment fee is paid in full prior to the start of treatment. This applies to patients paying in cash or check. This discount is not given if paying via Care Credit.
2. **Term Loan**: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 24 months) with no down payment, no annual fee, and no prepayment penalty. Longer payment terms are available at a nominal interest rate. Please ask for an application.

Broken appointments: A broken appointment is defined as an appointment that is cancelled or rescheduled with less than 48 business hours notice. (Business hours are Monday through Thursday). No-shows are also broken appointments.

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments.

We do not double or triple-book patients. If you do not show up for your appointment, there is no other patient for us to see.

We do not accept appointment cancellations through text or email within 48 business hours.

Broken appointment fees:

This is not intended to scare off patients but to stress the importance of keeping an appointment that you, the patient, has scheduled with us.

Hygiene Appointments: $55.00. Includes regular check-ups, regular cleanings, and periodontal maintenance

Periodontal Services with hygienist (Deep Cleanings, Deep Scalings) : 25% of the full treatment fee (not your co-pay)

Dr. McMurtry's appointments: 25% of the treatment fee (not your co-pay but the full fee of the visit)

We understand that emergencies may arise. At our discretion, a broken appointment fee **may be waived** due to these unforeseen circumstances.

Thank you for understanding this financial policy. If you have any questions concerning this, please ask before signing and accepting this policy.

Patient Name (Print)	Patient/ Guardian Signature	Date
Additional family member (minor child)	Additional family member (minor child)	Additional family member (minor child)
Additional family member (minor child)	Additional family member (minor child)	Additional family member (minor child)