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

Fellow of the Academy of General Dentistry

☐ Male ☐ Female **Patient's Information** Today's Date: ____________

Patient Name: ____ Nickname: ______________

Last First MI

Birth Date: __________________ Age: ________yrs ________ months or ___________ weeks

Address: ____

Street Apartment #

____

City State Zip Code

Parent's/Guardian Information

Parent 1 Name: ____

Last First MI

☐ Male ☐ Female ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Single

Social Security#:_____________________________ Birth Date: ______________________________

Phone (Cell or Home):________________________ Email Address: ___________________________

Employer: ________________________________ Occupation: ______________________________

Parent 2 Name: ____

Last First MI

☐ Male ☐ Female ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Single

Social Security#:_____________________________ Birth Date: ______________________________

Phone (Cell or Home):________________________ Email Address: ___________________________

Employer: ________________________________ Occupation: ______________________________

Referral Information

Who referred you to our practice: ☐ Pediatrician / 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: Georgia Tongue Tie Babies Support Group ☐ Facebook: Greater Charlotte Natural Birth and Parenting

☐ Facebook: Other: ____

☐ Other: ____

Please write down the individual name and not the clinic name

Pediatrician: ___________________________ **Fax:** (______) ______ - ________ Phone:(______) ______ - ________

Dentist: ______________________________ **Fax:** (______) ______ - ________ Phone:(______) ______ - ________

Speech Therapist: _______________________ **Fax:** (______) ______ - ________ Phone:(______) ______ - ________

Lactation Consultant: ____________________ **Fax:** (______) ______ - ________ Phone:(______) ______ - ________

Chiro/CST/OT/PT: _______________________ **Fax:** (______) ______ - ________ Phone:(______) ______ - ________

Patient's Name: ____

Has your child ever had any of the following? Please check those that apply:

- ☐ HIV or AIDS
- ☐ Epilepsy or Seizures
- ☐ Lung Disease or Problems
- ☐ Congenital Heart Lesion
- ☐ Hepatitis A, B, C
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Bleeding Problems
- ☐ Other: ____

Birth Weight: ______lbs ______oz   Current Weight: ________lbs______oz   When Last Weighed: _________

This is Child # ________ of _____.

☐ Yes ☐ No Is your child taking any medications? **If yes, please list** ______________________________

☐ Yes ☐ No Does your child have any allergies to any medications? If yes, please list ________________

☐ Yes ☐ No Has your child been treated by a physician or hospitalized in the past year?
If yes, please explain ____

☐ Yes ☐ No Do **you or your child** brush their teeth at least 2 times per day?

☐ Yes ☐ No Does your child snore (when not sick or congested)?

☐ Yes ☐ No Does your child have any speech issues, including L, T, D, N, SH, TH, or S sounds? **(CIRCLE)**

☐ Yes ☐ No Does your child have a history of dental decay (cavities)?

☐ Yes ☐ No Does your child have a problem with eating solid foods?

At rest, does your child breathe through their **NOSE** or **MOUTH ? (Circle)**

☐ Yes ☐ No Any family or sibling history of tongue-tie, lip-tie, or buccal-tie issues?

☐ Yes ☐ No Was your child born premature? If yes, born at ____ weeks. Reason: ______________________

☐ Yes ☐ No Did your child receive Vitamin K at birth?

☐ Yes ☐ No Is/ was your child breast-fed? If yes, for how long? ______________________________
Why did you stop nursing? ____

Does/did your child have any of the following problems? (check all that apply)

- ☐ No effective latch on
- ☐ Unsustained latch
- ☐ Slides off nipple
- ☐ Gumming or chewing on nipple
- ☐ Poor Weight gain
- ☐ Failure to thrive
- ☐ Unsatisfied hunger after feeding
- ☐ Prolonged feeding times
- ☐ Unable to hold pacifier
- ☐ Falling asleep at breast
- ☐ Upper lip blisters
- ☐ Upper lip curls in when feeds
- ☐ Gas
- ☐ Colic symptoms
- ☐ Reflux, incl silent or active
- ☐ Clicking sounds
- ☐ Supplements with bottle
- ☐ Thrush
- ☐ Frustration when feeding (arches back, flails arms, bobs or swings head)

☐ Bottle issues **(CIRCLE)**: Refuses, Leaking, Dribbling, Choking, Hacking, Coughing, Gagging, Clicking

☐ Others: ____

Have you, the mother, experienced any of the following when breastfeeding? (check all that apply)

- ☐ Feelings of depression
- ☐ Severe Pain with latch-on
- ☐ Continued pain during nursing
- ☐ Gumming or chewing on nipple
- ☐ Incomplete breast drainage
- ☐ Oversupply of breast milk
- ☐ Undersupply of breast milk
- ☐ Using a nipple shield
- ☐ Mastitis
- ☐ Thrush
- ☐ Infected nipples
- ☐ Using a SNS to feed child
- ☐ Recurring Plugged ducts: last plugged duct : ______________________________

☐ Nipple trauma **(CIRCLE)** : Sore, Cracked, Bruised, Bleeding, Blistered, Creased, Blanched or Flattened nipples

☐ Others: ____

Doctor notes:____

____

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____

B R I A N A . M c M U R T R Y , D. D. S., P.A.
10816 Black Dog Lane, Suite 100, Charlotte NC 28214

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 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

Acknowledgement of Receipt Of Notice of Privacy Practices

Available in-office and online at www.charlottelaserdentist.com/notice-of-privacy-practices.html

Name: ____

I have read/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.

PLEASE ENSURE TO INCLUDE ANY AND ALL HEALTH CARE PROFESSIONALS SO THEY CAN RECEIVE OUR REPORT.

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/Other Parent:	☐Family billing information ☐Medical
☐ Pediatrician (name listed on first page)	☐ Doctor's Report
☐ Dentist (name listed on first page)	☐ Doctor's Report
☐ Speech Therapist (name listed on first page)	☐ Doctor's Report
☐ Lactation Consultant (name listed on first page)	☐ Doctor's Report
☐ Other: ______________________________	☐ Doctor's Report

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