



BRIAN A. McMURTRY, D. D. S., F. A. G. D.
Fellow of the Academy of General Dentistry

Male Female

Child's Information

Today's Date: _____

Patient Name: _____ Nickname: _____
Last First MI

Social Security#: _____ Birth Date: _____ Age: _____ Grade: _____

Address: _____
Street Apartment #

City State Zip Code

Parent's/Guardian Information

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

Male Female Married Divorced Separated Widowed Partnered Single

If Divorced, who is the Legal and Financial Person responsible for your child: _____

Social Security#: _____ Birth Date: _____

Phone (Cell): _____ Email Address: _____

Phone (Home): _____ Phone (Work): _____

Address: _____
(if different) Street Apartment #

City State Zip Code

Employer: _____ Occupation: _____

Referral Information

Whom may we thank for referring you to our practice / How did you hear about us?

Name of person or office referring you to our practice: _____

- Internet (please circle): Google / Yahoo / Bing / Other. What was search term? _____
- New Homeowner Brochure w/magnet Mountain Island Monitor School Folder (MICS , MIE)
- Saw our sign driving by Postcard in mail Local Sports (Baseball / Soccer)
- Little Ones Magazine 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

Medical History

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

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

- Yes No Has your child been told they need to take antibiotic premedication prior to their dental appointment?
- Yes No Has your child ever smoked cigarettes or do they currently smoke cigarettes?
If yes, for how many years? _____. How much per day? _____ = _____ packs per day.
- Yes No Does your child have any allergies to any medications? If yes, please list _____
- Yes No Is your child taking birth control pills or other hormones?
- Yes No Has your child been treated by a physician or hospitalized in the past year?
If yes, please explain _____

Name of Pediatrician / Clinic: _____ Phone: _____

Why did you bring your child to see us today? _____

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

Who was your child's former dentist? _____ City/State: _____

- Yes No Did your child see this dentist regularly? (every 6 months for cleanings and checkup exams)
- Yes No Is your child having any pain or discomfort at this time? If yes, where: _____
- Yes No Has your child ever had a serious or difficult problem associated with previous dental work
If yes, please explain: _____
- Yes No Does your child brush their teeth at least 2 times per day with a soft bristled or electric toothbrush?
- Yes No Does your child use a toothpaste with fluoride or xylitol?
- Yes No Does your child floss at least 5 times per week? If no, how many times per week? ___ or per month? ___
- Yes No Has your child ever been told they have "gum disease" or "gingivitis" or had "gum surgery"?
- Yes No Are you happy with the appearance of your child's teeth/gums/smile?
If not, please explain what you don't like _____
- Yes No Are you happy with the color of your child's gums?
- Yes No Are you interested in straightening your child's teeth without braces (Invisalign)? (if appropriate age)
- Yes No Does your child have issues with L, T, D, N, SH, TH, or S sounds?
- Yes No I don't know Is your child tongue-tied or lip-tied ?
- Yes No Was your child breast-fed? If yes, for how long? _____
Why did you stop nursing? _____
- Yes No I don't know Do you notice plaque build-up on your child's teeth between brushings?
- Yes No Does your child take medications daily? If yes, how many? _____
- Yes No Do you feel like your child has a dry mouth at any time of the day or night?
- Yes No Does your child drink liquids other than water more than 2 times daily between meals?
- Yes No Does your child snack daily between meals?
- Yes No Does your child have oral appliances present?

Please list any Medications, Herbal Supplements, or Vitamins your child is taking

Medication	For what condition is this medication taken?	Medication	For what condition is this medication taken?

If your child is taking more than 6 medications, continue on other side or supply separate medication list

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.
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Medical
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Family Billing Information <input type="checkbox"/> Medical
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> 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 _____

DL: _____

AV: _____



BRIAN A. McMURTRY, DDS, FAGD

Fellow of the Academy of General Dentistry

Family & Cosmetic Dentistry

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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)