BRIAN A. McMURTRY, D.D.S., P.A.

Family & Cosmetic Dentistry

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____

Phone (Work): _____

Phone (Cell): _____

Email Address: _____

Address: _____
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?

☐ New Homeowner Letter w/magnet ☐ Mountain Island Monitor ☐ Yellow Pages book
☐ Saw our sign driving by ☐ Postcard in mail ☐ Internet: _____
☐ Another patient ☐ Another Dental Office ☐ Other: _____

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

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.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to you and that you are personally responsible for payment of all dental services. This office will help prepare your insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time services are rendered. I also agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- 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.

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

Medical & Dental History

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

☐ ADD/ADHD	☐ Chemotherapy / Radiation	☐ Head Injuries	☐ Mental Disorders	☐ Stroke
☐ AIDS or HIV	☐ Chest Pain	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Problem
☐ Alcohol Addiction	☐ Congenital Heart Lesion	☐ Heart Murmur	☐ Nervous Disorders	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ Hepatitis A, B, or C	☐ Pacemaker	☐ Tumors or Growths
☐ Arthritis / Gout	☐ Drug Addiction	☐ High Blood Pressure	☐ Respiratory Problems	☐ Ulcers / Stomach Problems
☐ Artificial Joints or Valves	☐ Eating Disorder	☐ Hypoglycemia	☐ Rheumatic Fever	☐ Venereal Disease
☐ Asthma	☐ Epilepsy or Seizures	☐ Jaundice	☐ Rheumatism	☐ Cold Sores / Fever Blisters
☐ Blood Disease	☐ Excessive Thirst	☐ Kidney Disease	☐ Scarlet Fever	☐ Frequent Headaches
☐ Bleeding Problems	☐ Fainting or Dizziness	☐ Liver Disease	☐ Sinus Trouble / Hay Fever	☐ Pain in Jaw Joint
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Steroid / Cortisone Medicine	☐ Any Other Condition

Date of Last Dental Visit: _____ Who was your former dentist?_____ City/State: _____

- Have you ever been told you needed to take antibiotics prior to your dental appointment?..... ☐ Yes ☐ No
- Do you use tobacco?..... ☐ Yes ☐ No

  If "Yes," what kind? _____ How often? _____ How long?_____
- Do you have any allergies? If yes, to what? _____ ☐ Yes ☐ No
- Have you had any unusual reaction to "Novocain" or local anesthetic?..... ☐ Yes ☐ No
- Pregnant or possibly pregnant? If **Yes**, when are you due?_____ ☐ Yes ☐ No
- Taking birth control pills or other hormones?..... ☐ Yes ☐ No
- Have you been treated by a physician or hospitalized in the past year?..... ☐ Yes ☐ No

  If yes, please explain:_____
- Has there been any change in your general health in the past year?..... ☐ Yes ☐ No

  If yes, please explain:_____
- Name of Physician: _____ Phone:_____

  Name of Cardiologist (if applicable): _____ Phone:_____
- Are you having any pain or discomfort at this time?..... ☐ Yes ☐ No

  Explain: _____
- Are you nervous about having dental treatment?..... ☐ Yes ☐ No
- How do you presently take care of your teeth and gums?

  Toothbrush: ☐ Soft Bristle ☐ Hard Bristle ☐ Electric:_____ How often? _____

  Floss: ☐ Yes ☐ No How often? _____ Other: _____

  Fluoride Toothpaste: ☐ Yes ☐ No Fluoride Rinse: ☐ Yes ☐ No
- Have you ever been told you have "gum disease," "pyorrhea," or "gingivitis"?..... ☐ Yes ☐ No
- Does your mouth seem dry?..... ☐ Yes ☐ No
- During the day, do you eat and snack on sugary foods, drinks, gum or mints?..... ☐ Yes ☐ No
- Do you like your smile?..... ☐ Yes ☐ No

  If no, please explain: _____
- Are you interested in whitening your teeth ? …….. ☐ Yes ☐ No

Medication List

Medication	Reason taken	Dosage	Medication	Reason taken	Dosage
Please use the back of this form if you need more room					

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 health, I will inform the doctors at the next appointment without fail.

✶ _____ _____ Date:_____

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

Doctor Signature: _____ Date: _____/_____/_____

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

Referral Information

If someone else referred you to our office, may we include your name in a thank you letter to them?

☐ Yes ☐ No

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 _____