Murry + Kuhn Dentistry

Dr. Don Murry Jr., Dr. Todd Kuhn, Dr. Don Murry III, Dr. Ken Murry, Dr. Brittney Murry

Name _____Birth Date_____

Address_____Zip_____

Email address_____Phone (H)_____(C)_____

Employer _____ Social Security # _____

Spouse's Name _____ Birth Date _____

Spouse's Employer _____ Social Security # _____

In case of emergency, who should we notify? _____Phone _____

Who should we thank for referring you to us? _____

Will you be paying by cash _____ check _____ credit card _____ insurance _____?

MEDICAL QUESTIONS (Answer Y or N)

Are you in pain now? ____ Are you under the care of a physician? ____ Have you had joint replacement surgery or a heart condition that may require pre medication? ____ Do you have diabetes, liver, or kidney disease? ____ Do you have asthma or lung disease? ____ Are you pregnant? ____ Have you tested positive for HIV virus? ____ Do you have AIDS? ____ Do you have Hepatitis? ___ Have you had serious trouble with any dental treatment? ___

Please list any disease or condition that you think we should know _____

Have you or are you currently taking any of the following medications? Aredia, Bonefos, Zometa, Actonel, Boniva, Didronel, Fosamax, Fosamax Plus D, or Skelid? (Please circle)

List any medications you are taking.

_____

List any medications you are allergic to. _____

AGREEMENT Payment is due at the time of service. For patients with dental insurance, co-payment and deductibles are due at the time of service. I/we authorize Dr. Murry Jr, Dr. Todd Kuhn, Dr. Don Murry III,or Dr. Ken Murry to render dental services to myself or child and authorize the release of information regarding medical and dental history, diagnosis, and treatment of myself or child to my insurance company regarding claim benefits. I/we authorize payment of dental benefits to Murry+Kuhn Dentistry. I/we agree to pay or dental services for myself, my spouse, or child and further understand that there will be a monthly billing charge of 1.5% on any balance over 90 days. Also should our account have to be referred to attorney for collections, I/we will be responsible for all costs and fees incurred. I also consent to have a blood test if an employee receives an injury with an instrument that was used in my treatment.

Signature _____

Relationship to patient _____ Date _____