



Medical health history

Patient name _____ Birthdate _____

INSTRUCTIONS TO THE PATIENT:

Answer the following questions as completely and accurately as possible. All information is CONFIDENTIAL. Please circle "yes" or "no" to all questions, and write in your answers as appropriate.

1. A. Are you under the care of a physician at this time or within the past six months? (not regular check -ups)
YES NO
 If yes, for what condition? _____

B. Have you been hospitalized or had any surgeries/procedures in the past 12 months? YES NO
 If yes, please explain? _____

2. Are you allergic to any medicines, drugs, latex or other substances? **YES NO**
 If so, please specify: _____

3. Have you ever taken appetite suppressant drugs such as Phen-Fen? **YES NO**
 If so, please list: _____

4. Are you happy with your smile? **YES NO**
 If not, what would you change? _____

5. Do you smoke and or use tobacco products? **YES or NO**

6. Do you have or have you had any of the following diseases/problems? **PLEASE CHECK YES OR NO**

	YES	NO		YES	NO
A. Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	M. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
B. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	N. Diabetes (list type)	<input type="checkbox"/>	<input type="checkbox"/>
C. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	O. Active tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
D. Heart valves – damaged/replaced	<input type="checkbox"/>	<input type="checkbox"/>	P. Kidney/renal disease	<input type="checkbox"/>	<input type="checkbox"/>
E. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Q. Hepatitis/jaundice (list type)	<input type="checkbox"/>	<input type="checkbox"/>
F. Heart murmur/inborn heart defects	<input type="checkbox"/>	<input type="checkbox"/>	R. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
G. Angina	<input type="checkbox"/>	<input type="checkbox"/>	S. Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
H. Infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	T. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
I. Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	U. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
J. Unshielded pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	V. Cancer/chemotherapy/radiation	<input type="checkbox"/>	<input type="checkbox"/>
K. HIV/AIDS or other STDs	<input type="checkbox"/>	<input type="checkbox"/>	W. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
L. Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	X. Bleeding gums/chronic bad breath	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any YES answers:

6. Do you have any disease, condition, or problem not listed above that would pose a significant risk to the health or safety of yourself or others during performance of dental procedures? If so, please explain:

7. Please list any **premedication, medications, pills, or drugs** which you are currently taking - both prescription and nonprescription - especially **anything you have consumed within the last 24 hours**. (There are some drugs that may interact with local anesthetics and can put you at risk.)

WOMEN ONLY: Are you pregnant? **YES NO** If yes, what is the expected due date? _____

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold Lyndhurst Dental responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE: _____ **DATE:** _____

(parent/guardian signature if under 18)



Tony Porter, DDS Ashley P. Ayuso, DDS

Patient Information

Name: Preferred name:
Male Female Married Single Child Other
Social Security #: Birth Date:
Phone (Home): (Work): Ext: (Cell):
E-Mail address:
Emergency contact: #:
Mailing address: Street Apartment #
City State Zip Code
Employer's name: Employer ph#:

DENTAL PLAN Subscriber/Guarantor Information

Patient is also the subscriber.

****IF YOU ARE THE POLICY HOLDER YOU DO NOT NEED TO COMPLETE THIS SECTION

Name: Preferred Name:
Male Female Married Single Child Other
Social Security #: Birth Date: Driver's License #
Phone (Home): (Work): Ext: (Cell):
E-Mail Address: (OPTIONAL)
Mailing Address: (IF DIFFERENT THAN ABOVE)
Street City Zipcode

DENTAL INSURANCE INFORMATION

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company does not pay on your claim, you are expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim. Please provide us with the following information in order to file your claim:

Company Where Employed:
Insurance Company Name:
Insurance Company Phone Number:
Insurance Company Address:
Insurance Company Group Number:
Insurance ID Number (If different than SS#):



Tony Porter, DDS Ashley P. Ayuso, DDS

OFFICE FINANCIAL POLICY

We are not contracted with any dental insurance company. We are out-of-network providers.

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you **read, understand and sign prior to any treatment.**

We are committed to providing you with the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. **There will be a fee of \$35 dollars for appointments are cancelled without 24 hour notice. Please ask if you have any questions about our fees, our financial policy, or your responsibility.**

Payment is requested at each appointment as service is rendered and can be made by cash, check, MasterCard, Visa, Discover or American Express. **Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses.**

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits AFTER you are a patient of record with us. In other words, **you must pay in full when you first come to our office.** Once we have verified your insurance benefits, we will begin filing your claims for you. **We estimate what we think it will be and we ask that you pay the remaining balance at the time the services are rendered. Once the insurance company reimburses us, if there is still a balance, you will be billed the remaining portion. WE ARE NOT CONTRACTED WITH ANY DENTAL INSURANCE COMPANIES.**

*****WE DO NOT FILE NC HEALTHCHOICE OR MEDICAID**

★ DELTA DENTAL & BCBS of NC SUBSCRIBERS / PATIENTS ★

Our office does not participate with any dental company networks therefore Delta Dental/BCBS of NC will not allow assignment of benefits and requires that all insurance payments be mailed to the subscriber. It is our policy in this situation to collect payment in full for any service rendered on the date the service is performed.

PATIENTS WITH INSURANCE: You, the patient, are responsible for your entire account balance. Patient portions are collected at each visit. If, for some reason, your insurance company does not pay on your claim, you are expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim. We will use the information provided on the previous form in order to file your claim.

I authorize the release of any information concerning mine or my child's dental care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

(Please print patient's name here.)

Signature of patient, parent or guardian

Date



Tony Porter, DDS Ashley P. Ayuso, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read/received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

I hereby authorize the release of my protected health information to be disclosed to the following individual(s):

Name:

Relationship to patient:

_____	_____
_____	_____
_____	_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)