FOR OFFICE USE ONLY
Reviewed by:

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

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

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 Drs. Porter/Holder 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 White, DDS Michael Bost, DDS

Patient Information

Name: ______________________________ Preferred name: ____________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________________

Social Security #: ____________________ Birth Date: ______________________________

Please use the ☐ to check your preferred method of contact.

Phone (Home): ☐ ____________________ (Work): ☐ ____________________ Ext:______ (Cell): ☐ ____________________

E-Mail address: ____

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 # ____________________

Please use the ☐ to check your preferred method of contact.

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:

Employee Name: ____

Employee Date of Birth: ____

Company Where Employed: ____

Insurance Company Name: ____

Insurance Company Phone Number: ____

Insurance Company Address: ____
Street City State

Insurance Company Group Number: ______________________________

Insurance ID Number (If different than SS#): ______________________________

Tony Porter, DDS Ashley White, DDS Michael Bost, DDS

OFFICE FINANCIAL POLICY
All patients must sign this form whether you have insurance or not

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. ***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.***

★ 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 White, DDS
Michael E. Bost, 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)