Patient Health History

Charles A. Porter, III, D.D.S.
135 S. Sharon Amity Road
Suite 200
Charlotte, NC 28211
704-364-9000
www.charlottedentalcare.com

Today's Date _____

Patient Name _____ SS# _____

Address _____ City _____ State _____

Zip _____ Home phone number _____ Work phone _____

Cell phone _____ Email _____ Referred by _____

Employer _____ Occupation _____

Date of Birth _____ Age _____ Sex: M or F Marital Status _____

Closest Relative _____ Phone _____

General Health (circle one) Excellent Good Fair Poor
Has there been any change in your general health in the past year? YES NO
Physician's Name and Phone # _____
Have you had any serious illnesses or operations? YES NO
Explain _____

CIRCLE ANY APPLICABLE DISEASES OR PROBLEMS:

Heart Disease
Mitral Valve Prolapse
High Blood Pressure
Low Blood Pressure
Hemophilia
Fainting Spells
Hives or Skin Rash
Cancer
Arthritis
Stroke
Anemia
Diabetes
Chronic Pain
Rheumatic Fever
Stomach Ulcers
Tuberculosis
Epilepsy
Hepatitis A, B or C
Kidney Trouble
Candida
Acid Reflux
Sexually Transmitted Disease
Positive HIV or ARC
Herpes
Sores or Ulcers in mouth
Artificial Joint Replacement

CIRCLE ANY MEDICATIONS THAT YOU HAVE AN ALLERGY TO OR HAVE HAD AN ADVERSE REACTION:

Local Anesthetics
Penicillin
Tetracycline
Aspirin
Acetaminophen
Sulfa Drugs
Other Antibiotics
Iodine
Codeine
Ibuprofen
Other: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO

Please List:

_____

_____

DO YOU WEAR

Contact Lenses	Yes	No
Pacemaker	Yes	No
Hearing Aid	Yes	No

Do you use any tobacco products? _____

Have you had any abnormal bleeding with previous extractions, surgery or trauma? _____

Have you ever required a blood transfusion? _____

If yes, explain

_____

Have you had any surgery, radiation, treatment for a tumor, or growth or any other condition of your mouth or lips?

_____

Have you ever had any serious trouble associated with any previous dental treatment?

_____

Do you have any disease, conditions, or problem not listed that we should know about?

Woman: Are you pregnant? Yes No

The above information is accurately completed and the patient hereby authorizes the doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to do any and all forms of treatment , medication, and therapy that may be indicated, and further authorize the doctor to choose and employ such assistance as he deems necessary. I also understand that the use of anesthetic agents embodies some risk.

Patient Signature_____ Date_____

Signature of Person Responsible for Payment

_____Date_____

(Charles A. Porter, III, DDS)

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
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 _____

Signature _____

Date _____

CHARLES A. PORTER, III, DDS
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Charles A. Porter, III, DDS is authorized to release protected health information about the above named patient in the following manner and to persons listed.

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.
☐ Voice Mail	☐ Appointment Reminders
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Treatment Plans ☐ Appointments
☐ Parent (provide name and phone number) ☐ Grandparent, Stepparent, Nanny Etc. _____	☐ Financial ☐ Treatment Plans ☐ Appointments
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014

Dr. Charles Porter III
135 South Sharon Amity Rd
Suite 200
Charlotte, NC 28211
(704) 364-9000
www.CharlotteDentalCare.com

Dear Patient:

In an effort to manage our appointment schedule and respond to all appointment requests, we will be implementing our No-Show and Late Cancellation policy effective immediately. The purpose of this policy is to efficiently manage office staff and allow us to open appointment times for patients waiting to be seen.

This policy requires you to inform us as early as possible if you will not be able to keep your appointment. The minimum expected notification of cancellation is 24 hours prior to the time of your appointment. While we are hesitant to implement penalties for non-compliance to this policy, we realize that every rule must have some enforcement provision in order to be effective. The policy implements a level of enforcement while also realizing that unexpected developments occur in all of our lives. It is our hope and desire to never have to use this policy since the majority of our patients provide us this courtesy. Unfortunately, as we try to accommodate all of our patient's needs, we have had an increasing number of no-shows which has resulted in implementing this policy.

No-Show and Late Cancellation Policy

- 24 hour notification given prior to any cancellation of an appointment.
- First offense is excused.
- Second and all subsequent offenses may result in a $35 no-show fee.

We understand that emergencies and unexpected events do occur and have taken this into consideration. We appreciate your cooperation and future courtesy in notifying the office of cancellations. Please provide your signature below indicating that you have received and understand our No-Show and Late Cancellation policy. Thank you.

_____ _____

Signature Date

_____

Printed Name

DR. CHARLES PORTER IS NOT IN NETWORK WITH ANY OF THE DENTAL INSURANCE COMPANIES. THEREFORE PATIENTS ARE REQUIRED TO PAY ANY BALANCE THAT THEIR INSURANCE CO. DOES NOT COVER.

PATIENTS WITH DELTA DENTAL ARE REQUIRED TO PAY IN FULL FOR SERVICES RENDERED. DELTA DENTALS POLICY IS TO ONLY PAY THE INSURED NOT THE PROVIDER OF SERVICES.

THANK YOU

_____(patient’s signature)

CHARLES A. PORTER III, DDS
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I, _____, give Dr. Charles Porter III my permission to use the photography that he has taken of my teeth. This photography may be used in case presentations with other doctors, on our website, and/or in Dr. Porters office for other patients to view as potential treatment options for their dental needs.

_____

Signature of Patient Date