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Thank you for choosing and trusting us with your dental care. Please complete these forms so we can better serve you!

Confidential Patient Information

Personal Information:

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET NAME

CITY STATE ZIP CODE

Phone: Home _____ Work _____ Cell _____

Email _____ Sex: Male Female Pronouns: _____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Widowed Divorced/Separated

Emergency Contact: Name _____ Phone _____ Relationship _____

How did you hear about our office? Is there someone we can thank for referring you? _____

Dental Insurance

Primary Insurance Information:

Subscribers Name: _____

Subscribers SSN #: _____

Subscribers Date of Birth: _____

Insurance Company: _____

Employer: _____

Subscriber ID: _____

Group Number: _____

Secondary Insurance Information:

Subscribers Name: _____

Subscribers SSN #: _____

Subscribers Date of Birth: _____

Insurance Company: _____

Employer: _____

Subscriber ID: _____

Group Number: _____

I hereby, authorize payment directly to West Asheville Family Dentistry for services rendered. I understand that benefits explained to me are only estimates, and I understand that I am responsible for cost of all dental treatment regardless of insurance.

Signature: _____

Date: _____

Responsible Party (if different than patient)

Name _____ Relationship to Patient _____

Social Security _____ Birth Date _____ Phone _____

Address _____
STREET NAME

CITY _____ STATE _____ ZIP CODE _____

Dental Information

When was the last time you were seen by a dentist? _____ Were dental radiographs taken? Yes No

How many times a day do you brush? _____ How many times a week do you floss? _____

Please list any additional hygiene products you use regularly (mouth rinse, tongue scraper, etc.) _____

Have you ever been told that you have a gum or periodontal problems? Yes No If yes, please explain: _____

Do you have any sores or growths in or around your mouth? Yes No If yes, please explain: _____

Do you clench your teeth? Yes No Do you grind your teeth? Yes No

Do you have pain in your jaw joints (TMJ)? Yes No Do you suffer from dry mouth? Yes No

Have you ever worn any type of appliance or night guard? Yes No

Do you experience excessive snoring or sleep apnea? Yes No

Describe any difficulties you may experience when chewing: _____

Do you feel nervous about having dental treatment? Yes No

Have you ever bleached your teeth? Yes No Are you interested in doing so? Yes No

Are you happy with your smile? Yes No If no, please describe why: _____

Consent To Treatment

I authorize and give consent to Brent H. Barroso-Bernier D.D.S. and associates to perform dental services agreed upon between doctor and patient. I am responsible for informing the doctors about any changes about medical history prior to treatment. I understand that this medical information will be used as necessary for diagnosis and treatment.

Payment for all treatment and services rendered are my responsibility. Your estimated copayment for treatment, which is that amount not covered by your insurance, is due at the time treatment is rendered. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments.

Patient/Guardian Signature: _____ Date: _____

Cancellation Policy

In order to provide quality dental care in an effect manner, we ask that you give us at least **24 hour notice** of a cancellation. Cancellation with less than a **24 hour notice** and no shows are subject to a \$75.00 charge to one's account. We understand that there are unavoidable situations and inconveniences in everyone's life, but three missed appointments without proper notice will result in dismissal from our office.

Your signature below verifies that you have been informed of this office policy. Thank you for your cooperation!

Patient/Guardian Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you vape, use tobacco, or e-cigarettes? Yes No
- Do you use controlled substances including marijuana and all of its various forms and variants? Yes No

Women: Are you
 Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your signature below indicates that you have received a copy of West Asheville Family Dentistry's Notice of Privacy Practices.

Patient Name (Printed)

Date of Birth

Patient or Legally Authorized Individual (Signature)

Today's Date

Verbal Communication Release

Many times our patients may want us to verbally communicate with a friend or family member about scheduled appointments, treatments, and finances. Please list below any friends or family members whom you authorize us to discuss your dental care or financial information with. I understand that West Asheville Family Dentistry is not responsible for the information provided as long as it is given to a person that is listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name (Printed)

Date of Birth

Relationship

Name (Printed)

Date of Birth

Relationship

Name (Printed)

Date of Birth

Relationship

I do not authorize West Asheville Family Dentistry to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient or Legally Authorized Individual (Signature)

Date