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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

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 North 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 \$25.00 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: \_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

Your signature below indicates that you have received a copy of North 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, treatment, 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 North 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 North 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

## MEDICAL INFORMATION

Physician Name:

Physician Phone:

Date of Last Exam:

Have you been seen by your physician for any ongoing conditions or been hospitalized over the past 5 years?

YES  NO If yes, please describe: \_\_\_\_\_

Please list any medications (prescription or over-the-counter) you are currently taking:

\_\_\_\_\_

Are you allergic to any medications/materials (penicillin, aspirin, sulfa, codeine, metals, latex, and jewelry)?

YES  NO

If yes, please list: \_\_\_\_\_

*Check any of the following that you have had or have at present:*

- |  |   |   |  |                                       |
|--|---|---|--|---------------------------------------|
| <input type="checkbox"/> Heart Problems            | <input type="checkbox"/> HIV/ARC/AIDS                 | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Anaphylaxis  |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Heart Murmur (MVP)        | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Hepatitis B            | <input type="checkbox"/> Bleeding/Bruising Problem |                                       |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Thyroid Disease              | <input type="checkbox"/> Chronic sinus Problems | <input type="checkbox"/> Hepatitis C               | <input type="checkbox"/> Acid Reflux  |
| <input type="checkbox"/> Epilepsy/seizure disorder | <input type="checkbox"/> Cancer/chemotherapy          | <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Diabetes                  |                                       |
| <input type="checkbox"/> Radiation Therapy         | <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> Joint Replacement      | <input type="checkbox"/> Psychological Treatment   |                                       |
| <input type="checkbox"/> Asthma/Inhaler use        | <input type="checkbox"/> Sexually Transmitted Disease |   |  |                                       |

Please list any major surgeries: \_\_\_\_\_

Please elaborate OR describe any conditions not listed above: \_\_\_\_\_

Do you use any tobacco products?  YES  NO

If yes, what type and how do you use them: \_\_\_\_\_

WOMEN: Are you pregnant, or trying to become pregnant?  YES  NO