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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 PREFERRED NAME

Address_____
STREET NAME

_____
CITY STATE ZIP CODE

Phone: Home _____ Work _____ Cell _____

Email _____ Sex: ☐ Male ☐Female ☐Other/Pronoun(s)_____

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 your last professional dental cleaning? _____ 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, ect.) _____
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 business day notice** of a cancellation. Cancellation with less than a **24 hour business day notice** and no shows are subject to a **$50.00** charge to one's account. We understand that there are unavoidable situations and inconveniences in everyone's life, but multiple 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