Arden Family Dentistry
2159 Hendersonville Rd.
Suite 10
Arden, NC 28704
☎: (828) 676-0065 🖷: (828) 676-1070
✉Email:office@ardenfamilydentistry.com

Welcome to our practice! Thank you for allowing us to serve your dental needs. We have provided the following information to ensure your first appointment goes smoothly.

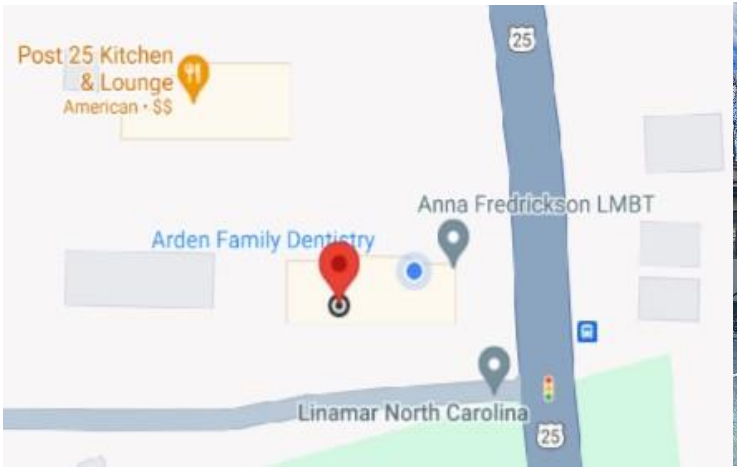
Please complete the attached forms and bring them with you to your first appointment, it will help speed up the check in process. You will need to arrive 15 minutes prior, to ensure we have all the information needed and ready by your scheduled appointment time.

If you have dental insurance, please bring all your current insurance cards as well as a valid photo id with you.

Patients with or without dental insurance please include your last dental office on the attached records release to ensure we get all recent x-rays before your appointment, failure to obtain these records could result in out-of-pocket expenses.

Plan on bringing any required copayments to your visit and it will be collected at the time of check out. Self-pay patients, payment in full at the time of service is required unless discussed otherwise.

Thank you! Our staff looks forward to meeting you soon!



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Confidential Patient Information

Personal Information:

Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address: _____
STREET NAME

_____
CITY STATE ZIP CODE

Phone: Home _____ Cell _____ Email: _____

Date of Birth: _____ Age: _____ Social Security #_____

Sex: ☐ Male ☐Female Preferred Pronouns: _____ Marital Status: _____

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 Arden 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.

Patient/Guardian Signature: _____ Date: _____

Responsible Party (Parent, Guardian, Medical POA)

Name _____ Relationship to Patient _____

Social Security _____ Birth Date _____ Phone _____

Address: _____
STREET NAME

_____
CITY STATE ZIP CODE

Dental Information

When was the last time you had your teeth cleaned? _____ 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, act.) _____

- 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? ☐ Yes ☐ No
- Have you ever worn any type of appliance or night guard? ☐ Yes ☐ No
- Describe any difficulties you may experience when chewing: _____
- Do you experience excessive snoring or sleep apnea? ☐Yes ☐ No
- Do you suffer from dry mouth? ☐ Yes ☐ No
- 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.**

I understand a finance charge will be applied to any account that is referred to any outside collection's agency.

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 $50.00 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

A laminated copy of this policy is located at the check in desk for you to review. If you would like your own paper copy, please request one from the patient coordinator at check in.

Your signature below indicates that you have read and understand Arden 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 Arden Family Dentistry is not responsible for the information provided if 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

☐ **I do not authorize Arden 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/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 use tobacco? ◯ Yes ◯ No

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____

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AUTHORIZATION TO RELEASE DENTAL RECORDS

PLEASE COMPLETE ALL SECTIONS, DATE AND SIGN.

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes ☐ Xrays

Entity or person who will receive the information:

Name: Arden Family Dentistry

Address: 2159 Hendersonville Rd, Suite 10

City, State, Zip Code: Arden, NC 28704 Phone: 828-676-0065

Email Address and Fax#: **office@ardenfamilydentistry.com /** 828-676-1070

This authorization will be in effect until the information has been forwarded or up to 90 days whichever comes first.

_____ _____

Signature of Patient or Personal Representative Date