Marion DDS
2218 Rutherford Road
Suite A
Marion, NC 28752
☎: (828) 652-2731 🖷: (828) 652-3690
✉ Email: info@mariondds.com

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

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 *Always bring current insurance card to appointments*

☐ **I do not have dental insurance and I am therefore prepared to pay in full for my appointment today.**

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 Marion DDS 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, 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 at 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 an outside collection's agency.

Patient/Guardian Signature: _____ Date: _____

Cancellation Policy

In order to provide quality dental care in an efficient manner, we ask that you give us at least a **24-hour business day notice** of a cancellation. Cancellations with less than a **24-hour business day notice** and no shows are subject to a **$35.00** 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 Marion DDS's Notice of Privacy Practices. A copy of this policy is available online at www.mariondds.com or displayed in our waiting area. Individual hard copies are available upon request.

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 Marion DDS 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 Marion DDS 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 _____

Marion DDS
2218 Rutherford Rd., Suite A ♦ Marion, NC ♦ 28752
Phone: 828-652-2731 ♦ Fax 828-652-3690

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: _____
Have you ever taken Fosamax, Boniva, Actonel or any other? _____
Medications containing bisphosphonates? ☐ Yes ☐ No
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Do you need to pre-medicate? ☐ Yes ☐ No If yes, please explain: _____

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

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

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

Medications: Please list **ALL** medications you are taking, including over the counter drugs and herbs:
_____
_____
_____
_____
_____

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

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health.

The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

Payment Options

- Payment is due at the time services are provided. Our office accepts cash, check, American Express, Discover, Mastercard and Visa.
- If you need to make long-term payments, we offer financing through Care Credit. One of our team members will be happy to help you with the application process. You must qualify prior to treatment to use this financing option.
- We reserve the right to charge a $35.00 fee on all returned checks.

Patients with Dental Insurance

- We are a non-participating provider (out of network) for all dental insurance companies other than Blue Cross Blue Shield of NC, Cigna PPO, and Liberty Dental through Blue Cross Blue Shield.
- If you are covered under a dental policy, please be prepared to present your dental insurance card, employer, and subscriber information (name, date of birth and social security number) before your appointment. Eligibility will be verified before being seated in the treatment room.
- As a courtesy, we will file your insurance claims. Upon your request, we will provide an insurance estimate to you; however, it is **not a guarantee** that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. You are responsible for monitoring the amount of your remaining benefits for any annual benefit period. Please contact your insurance company for details of your benefits**.**
- Insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Any deductible or co-payment amount will be due at the time of treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- **In some instances, insurance companies will not assign benefits (send payment) to an out of network provider**. If this is the case with your insurance company, you will be **required to pay the full amount at the time of your appointment**. You should receive reimbursement from your insurance company within 1-2 weeks. We will do our best to determine where benefits are assigned prior to your appointment. This typically applies to most **Delta Dental insurance policies.**

Overdue Accounts

- We reserve the right to apply a Finance Charge to any account sent to an outside collection agency.
- Any account sent to an outside collection's agency for non-payment will result in dismissal from the practice.

I have read and agree with the Patient Treatment and Financial Policy of Marion DDS

Signature of Financially Responsible Party Date

Printed Name of Financially Responsible Party