Patient Information

Date

Patient's Name _____ (LAST / FIRST / MIDDLE) DATE OF BIRTH

Address _____ (STREET / CITY / STATE / ZIP)

Home Phone _____ Cell Phone _____ Social Security # _____

Email Address _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ (LAST / FIRST / MIDDLE) MARITAL STATUS

Residence _____ (STREET / CITY / STATE / ZIP)

Mailing Address _____ (STREET / CITY / STATE / ZIP)

How long at this address? _____ Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Primary Insured's Name _____ Insured's Subscriber # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Do you have dual coverage? ☐ Yes ☐ No If Yes:

Insured's Name _____ Insured's Subscriber # _____

Insured's Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I certify that the information provided is true and accurate to the best of my knowledge.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

Patient Information

Date: _____ **Birthdate:** _____

Note: This information is necessary for our records. Please complete all parts. We consider it strictly confidential.

Name: _____

Last First Middle

Address: _____

Street City State Zip

Phone: _____

Home Work Cell email address

Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Physician: _____

Last complete physical: _____ Phone: _____

Do you smoke: ☐ Yes ☐ No How much? _____

Are you taking any medication? ☐ Yes ☐ No If yes, list medication name and purpose: _____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, list medication: _____

_____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Heart Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Blood Pressure - High/Low	☐ Yes ☐ No	Asthma/Hay Fever	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Alcohol Abuse	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
AIDS	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
Serious Accident	☐ Yes ☐ No	_____	

Have you had x-ray treatments (Not diagnostic)? ☐ Yes ☐ No

Women: Are you or do you suspect you are pregnant? ☐ Yes ☐ No

Joint replacements/implants? ☐ Yes ☐ No

Dental History

Date of last dental visit: _____ Dentist: _____

Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No

Have you had orthodontic treatment? ☐ Yes ☐ No

Do you clench or grind your teeth (day or night)? ☐ Yes ☐ No

Have you had pain in your jaw joint? ☐ Yes ☐ No

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you had gum disease or pyorrhea? ☐ Yes ☐ No

Do you have sensitivity to: ☐ Pressure ☐ Cold ☐ Hot

Does food or floss catch between your teeth? ☐ Yes ☐ No

Please add anything you feel is important for us to know: _____

Permit For Treatment

This is to certify that I, the undersigned, consent to the performing of the dental and the oral surgical procedures necessary or advisable, including the use of local anesthetics as indicated, by ***Asheville Aesthetic Dental Partners***.

Patient (parent or guardian) signature: _____ Date: _____

Interviewer's signature: _____

Asheville Aesthetic Dental Partners

Do you have morning headaches?	Y / N
Do you wake up tired?	Y / N
Do you gasp for breath at night?	Y / N
How long do you sleep at night?	hrs
Are you currently wearing a C-PAP?	Y / N
Have you had a sleep study?	Y / N

Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0=Would never dose
1=Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

SITUATION	
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. in theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 8 or greater indicates the possibility of sleep disordered breathing.

Thornton Snoring Scale

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner)

0=Never
1=Infrequently (1 night per week)
2=Frequently (2-3 nights per week)
3=Most of the time (4 or more nights per week)

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home (hotel, camping , etc.)	_____
TOTAL SCORE	_____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.

Patient Name _____ Date: _____

600 Alliance Ct.
Suite A-1
Asheville, NC 28806

Ph: 828.670.9894
Fax: 828.670.7107
www.ashedentalpartners.com

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement.

I,_____, have receive a copy of this office's Notice of Privacy Practices.

_____
Name of Patient

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however were unable to do so for the following reason:

- ☐ Individual Refused to Sign
- ☐ Communication Barriers Prohibited Obtaining Signature
- ☐ An Emergency Situation Prevented It

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Authorization for Release of Information

Name of Patient _____ **Date of Birth** _____

Asheville Aesthetic Dental Partners is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ **Spouse (provide name)** _____ _____	☐ Financial ☐ Dental as follows: _____ _____
☐ **Parent** (provide name) _____ _____	☐ Financial ☐ Dental as follows: _____ _____
☐ **Other** (provide name) _____ _____	☐ Financial ☐ Dental as follows: _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorizatrion may be sugject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

ASHEVILLE AESTHETIC DENTAL PARTNERS

FINANCIAL POLICY

Dental treatment is an excellent investment in you overall health and well-being.

Financial considerations should not be an obstacle to obtaining this important health service.

The following payment options are available:

CARE CREDIT, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, LAY-AWAY PLAN

Regardless of the option chosen, you are fully responsible for payment of all procedures performed in this office. Account balances extending beyond 60 days from treatment date will incur finance charges at the rate of 12% annually or 1% monthly.

Non-insurance accounts may save 5% by paying in full at the time of service with cash or check.

Down payment of 50% of the out -of -pocket total is required to reserve an appointment for lengthy and extensive procedures, as well as those involving lab time and expense.

RESERVATIONS/BROKEN APPOINTMENT POLICY

Our office provides several courtesies to help you keep your appointments. Every reasonable effort is made to confirm your RESERVATION 48 hours prior to your appointment. If we are unable to reach you, we ask that you contact us at lease 24 hours in advance to confirm your reservation or to cancel/ reschedule. Emergency situations will be evaluated on an individual basis. Failure to keep a scheduled appointment will result in a $75.00 charge.

RETURNED CHECK POLICY

Returned checks will not be presented to the bank a second time. A $25.00 fee will be charged and you will be responsible for any additional bank charges the practice incurs.

INSURANCE

Our experienced staff will file your insurance claim and help you to maximize your benefits. We ask that you pay deductibles and non-covered portions at the time of treatment.

I ACKNOWLEDGE RECEIPT OF THIS POLICY NOTICE

SIGNED_____ DATE_____

Effective August 29, 2019

ASHEVILLE AESTHETIC DENTAL PARTNERS

Insurance Authorization for Signature on File
Release of Information/Financial Responsibility
Authorization for Payment

This office files dental insurance claims as a courtesy service. Insurance estimates provided by our financial office are based upon existing plan benefit information and plan payment history and ARE NOT A GUARANTEE OF PAYMENT. Payment of your estimated portion is required from you at the time of service. Please be aware that you are fully responsible for any other portion your insurance fails to cover except where applicable discounts or third party deductions may apply. You are responsible for discovering whether your insurance plan may have waiting periods or other restrictions that might prevent payment of your claims. Claim payments must be received within 60 days of the claim filing date or full payment becomes your responsibility.

I, _____ and/or _____
Name of Patient (Parent or Guardian if Minor) Name of Primary Insured

do hereby authorize Asheville Aesthetic Dental Partners to affix my name and required information to all claims or documents as related to any health benefits due me and my dependents through _____ insurance plan. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed recommend treatment and fees. I agree to be responsible for all charges for dental services and materials no paid by my dental plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I authorize release of any information relating to the claim.

This "Authorization" is valid for one year from this date.
A photocopy of this document may act as an original.

_____ _____
Signature of Insured Patient (Parent or Guardian if Minor) Date