Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Mobile): _____ (Work): _____Ext:_____

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

***Do you require <u>antibiotic premed</u> prior to dental treatment*? Yes or No If yes, for what:_____**

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ A fibrillation
- ☐ Alcohol/Drug Abuse
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints: _____
- ☐ Asthma
- ☐ Blood Clots/Embolism
- ☐ Blood Disease
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnant Currently Due date:_____
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumers
- ☐ Ulcers
- ☐ Venereal Disease

<u>Medication Allergies</u>:

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other:_____

☐ **<u>Current Medication</u>**:

_____
_____
_____
_____
_____
_____

☐ **<u>Other Conditions</u>**:

_____
_____

- Are you currently taking ***Bisphosphonates for Osteoporosis***? ☐ Yes ☐ No
- Are you currently taking ***Blood Thinners***? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary Insurance Plan Name and Address: _____

Name of Insured: _____ Insured's Birth Date: _____
Last First MI

ID #: _____ Group #: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Subscriber Address if different than patient: _____
Street City State Zip Code

Insured's Employer Name or Group Name: _____

_____ I understand that Breeze Dental Care is considered an "Out of Network Provider" for my insurance company.

_____ I have been offered a copy of the information that my insurance company has given to Breeze Dental Care and understand that this is the only information that my insurance company has provided to Breeze Dental Care regarding reimbursement for my plan. (___accepted ___ declined)

Secondary Insurance Plan Name and Address: _____

Name of Insured: _____ Insured's Birth Date: _____
Last First MI

ID #: _____ Group #: Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Subscriber Address if different than patient: _____
Street City State Zip Code

Insured's Employer Name or Group Name:

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I hereby authorize Breeze Dental Care to take radiographs, study models, photographs or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my/my child's dental needs. I also authorize Breeze Dental Care to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discoverable during previous examinations. I give my permission to my dentist to make any/all changes and additions as necessary. Filling size is subject to change. All dental caries (decay) must be removed during restoration. Once accessed, caries may be larger than originally anticipated and may change the treatment and fees needed. Additional, unplanned procedures will be discussed with me, and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating Breeze Dental Care for any related attorney and or collection agency fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

I certify that the above insurance information is correct and in force.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize assignment of benefits from my insurance company to be paid directly to Breeze Dental Care.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian