Breeze Dental

A division of Atlantic Dental Care

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance.

We are happy to help!

Patient Registration Information

Date: _____

Name: _____ SS# _____

First MI Last

Home Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do you prefer to receive calls at: ____ Work _____ Home _____ Cell

Are you: ____ Minor _____ Single _____ Married _____Divorced_____ Widowed_____ Separated _____

Your or your parent/ guardian employer: _____ Occupation: _____

Business address: _____ City: _____ State: _____ Zip: _____

If you are a student, name of school/ college: _____ FT: _____ PT: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS# _____

Driver's license# _____ Birthdate: _____

Email: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? _____ Yes _____ No

Dental Insurance Information

Name of Insured: _____

Relationship to patient: _____

Birthdate: _____

Employer: _____

Address of employer: _____ City_____ State_____ Zip _____

Insurance company: _____ Group #_____ ID#_____

Additional Dental Insurance

Do you have any additional insurance? Yes____ No_____ If yes, please fill out the following:
Name of insured: _____ Relationship to patient: _____
Birthdate: _____ SS# _____
Employer: _____ Work #_____
Insurance company: _____ ID# _____ Group # _____

Authorization, Release, & Agreement to pay services rendered

_____ I authorize the Dr. to release any information re: the diagnosis/ records of any treatment/ exam rendered to me during the period of such dental care to 3rd party payors/ health practitioners.
_____ I authorize and hereby request my insurance company to pay directly to the dentist/ dental group insurance benefits otherwise payable to me.

_____ I understand that my dental insurance carried may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents'.

Financial agreement

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected in full at each appointment.

Cash _____ Personal Check _____ Credit Card _____ Care Credit _____

Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in no additional services except for dental emergencies unless they are prepaid. In the care of default of payment, I agree to pay attorney fees @ 33.33% and interest incurred in attempting to collect on this amount of any future outstanding account balances in addition to the original balance sent to collection.

Thank you for filling out the form completely. The information you have provided with help us serve your dental healthcare needs more effectively and efficiently. If you have questions at any time, please ask us. We are always happy to help.

Signature of patient or parent/ guardian if minor: _____ Date: _____

Breeze Dental
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Health History Update

Patients full name: _____ DOB: _____ Sex: M or F
Name of Physician:_____ Phone: _____ Last Exam _____

Are you having any discomfort at this time? YES or NO
Do you feel nervous about having dental treatment? YES or NO
Have you been under the care of a medical doctor during the past 2 years? YES or NO
Are you currently taking coumadin or any other blood thinner? YES or NO
Are you currently taking any medications? YES or NO
Please list: _____

ARE YOU ALLERGIC OR HAVE REACTED ADVERSLY TO ANY OF THE FOLLOWING:

Amoxicillin	Erythromycin	Penicillin
Aspirin	Tetracycline	Local Anesthetic
Codeine	Percodan	Sleeping Pills
Latex	Valium	Any other allergies _____
Nitrous Oxide	Scopolamine	

Have you ever been told that you need to be pre-medicated before dental work? YES or NO
Are you currently using tobacco products or have you use tobacco in the past? YES or NO
If YES, What? _____ How long? _____

Circle any of the following which you have had or have at the present:

A.I.D.S	Drug Addiction	Pain in Jaw Joints
Anemia	Emphysema	Periodontal Treatment
Angina Pectoris	Epilepsy/ Dizzy	Psychiatric Treatment
Arthritis	Fever Blisters	Radiation Treatment
Artificial Heart Valve	Glaucoma	Rheumatic Fever
Artifical Joints	Heart Disease/ Attack	Scarlet Fever
Asthma	Heart Murmer/ Pacemaker	Sickle Cell Disease
Blood Transfusion	Hemophilia	Sinus Trouble
Cancer	Hepatitis A/ B/ C	Stents Placed
Canker Sore	High Blood Pressure	Stroke
Congenital Heart Lesions	Kidney Trouble	Thyroid Disease
Cortisone Medicine	Liver Disease	Tuberculosis
Dental Implants	Mitral Valve Prolapse	
Diabetes	Orthodontics	

Is there anything else about your medical history that we should know? _____
FOR WOMEN: Are you pregnant? YES or NO Are you nursing? YES OR NO Birth control YES or NO

I understand that the above information is confidential and certify that it is correct to the best of my knowledge

Patient/ Parent or guardian signature: _____ Date: _____

Dental History Form

Patient Name: _____ Date: _____

Please describe the primary reason for your visit (Concerns)

1.)_____

2.)_____

3.)_____

How long has this been going on?

_____

_____

What would you like done?

_____

_____

If you could rate your smile from 1-10, what would it be?

_____

Would you like to improve your smile? Y or N How?

_____

Have you ever suffered from, or been told you may have any of the following?

Gum Disease **Y or N**
Bruxism **Y or N**
Jaw pain/ TMJ **Y or N**
Dental Pain **Y or N**
Snoring or stop breathing while sleeping **Y or N**
Bad Breath **Y or N**
Headaches or Migraines **Y or N**
Tooth sensitivity to hot/ cold **Y or N**

Doctor Notes:

Breeze Dental
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Acknowledgement of Receipt of Notice of Privacy Practices

~ You may refuse to sign this acknowledgement~

I have received a copy of this office's Notice of Privacy Practices

Signature: _____ Date: _____

I direct my health care providers to disclose and release my protected health information described below to the following individuals as well as any other medical professional in regards to any other medical treatment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization shall be in effect until (check one):
____ All past, present, and future periods or
____ Date and event: _____, unless I revoke it in writing

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ individual refused to sign
____ communication barriers prohibited obtaining the acknowledgement
____ Emergency situation prevented us from obtaining the acknowledgment
____ Other (specify)

Signature: _____ Date: _____

Broken Appointment policy and fees

When you reserve a time with us please make every attempt to make your appointment. This time is set aside specifically for you and your appointment is confirmed when it is made. Two weeks prior to your appointment you will receive a courtesy email, text message, or a phone call if you do not wish to receive text messages. This is a courtesy reminder not a confirmation call. We have a 2- business day cancellation policy and do not accept cancellations via voicemail. If you need to change or reschedule your reserved time with us, please call during regular business hours and give at least a 2-business day notice. This allows us to see other patients awaiting treatment. If you cancel, fail to show for your confirmed appointment, or arrive excessively late and treatment can not be completed as planned, a broken appointment fee will be assessed to your account.

Cancellation or rescheduling of an appointment within 48 hours or more notification- No charge

Cancelling or rescheduling of an appointment with less than 48 hours will be considered a broken appointment.

Failure to give 48-hour advance notice:

Hygiene- $50.00

Doctor Appointment scheduled for an hour or less $100.00, each additional hour incurs an additional fee of $50.00

Definition of "Broken appointment": A broken appointment is when you cancel or reschedule an appointment with less than 48-hour notice.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical in accomplishing that goal. When you reserve a time with us please make every attempt to make your appointment.

Late Arrivals:

If you are more than 15 mins late for your appointment, we reserve the right to reschedule your appointment for a later time.

I have read and understand the above-mentioned policy

Signature: _____ Date: _____