Thank you for visiting. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer ______________________ Drivers License ______________________

Birth Date ______________________ Social Security # ______________________

Phone: Home ______________________ ❑ Male ❑ Female

Mobile ______________________

Would you like to receive text message reminders of future appointments on your mobile phone?*

❑ Yes ❑ No (*Your phone carrier could charge additional fee for text messages)

Preferred number for text messages ______________________

Email Address ______________________

Emergency: Name ______________________ Phone ______________________

I give permission for messages or other communication relating to my dental treatment to be left at the contact information provided above __________ (please initial)

I give permission to release communication or other information relating to my dental treatment to the following individual other than myself:

Name

____

Insurance

Primary Carrier

Subscriber Name ______________________ Social Security # ______________ DOB __________

Employer ______________________ Insurance Co. ______________________

Insurance Co. Phone # ______________________ Group # ______________________

Relation to patient ______________________

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature ______________________________________ Date ______________________

If Patient is Under 18

Responsible Party ______________________ Relation to Patient ______________

Address ____
STREET

____
CITY STATE ZIP

Telephone ______________________

Other Information

How did you hear about us? ❑ Insurance ❑ Family / Friend ❑ Drive / Walk By ❑ Website

What was the reason for today's visit? ______________________

Are you concerned with the health of your gums? ❑ Yes ❑ No

Are you interested in whitening your teeth? ❑ Yes ❑ No

Are you interested in anti-snoring treatment? ❑ Yes ❑ No

What did you like *most* about your last dentist? ______________________

What did you like *least* about your last dentist? ______________________

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Joint Replacement
- ❑ Smoke

Are you allergic to?

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Other ______________________

Are you currently under the care of a physician?

❑ Yes ❑ No

Please list current medications:

____

____

Female Patients: Are you pregnant? ❑ Yes ❑ No

If yes, when is your due date?

____

Dental History

- ❑ Date of Last Cleaning ______________
- ❑ Date of Last Dental Visit ______________
- ❑ Deep Cleaning
- ❑ Teeth Whitening
- ❑ Teeth Sensitivity
- ❑ History of Sores in the Mouth

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility and I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance. If any, and all balances for services rendered goes to collection, I understand I am responsible for any filing, court, collection and/ or attorney fees.

______________________________ ______________________
PATIENT/GUARDIAN SIGNATURE DATE

MacArthur Ranch Center
8150 N. MacArthur Blvd. Suite 160
Irving, TX 75063
(972) 432-8811

At CoolBreeze Dentistry, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know………

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We currently accept many private care insurance plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is only an estimate.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."

CoolBreeze Dentistry does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, cash, and checks. We do not accept checks for over $500.00 for any patient. All non sufficient fund checks are subject to a $30 NSF charge.

If you are in need of an extended finance option, we also work with Care Credit, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice or a "no show" charge may apply**. Emergencies are an exception.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print: ____________________________________

Sign: ____________________________________

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.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We 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

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specifiy)

____

____