

Patient Information

Patient Name: _____ Preferred Name _____ Gender: _____ Date: _____

Birth Date: _____ Family Status: _____ Social Security #: _____ Drivers License #: _____

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

Address: _____
Street Apt # City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

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

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

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

Have you ever had any of the following? Please check YES or NO:

- | Y N | Y N | Y N | Y N |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet / |
| <input type="checkbox"/> Artificial Joints/Hips | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Lung Disease | Ankles or Hands |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Have you ever taken | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood Transfusion | Phen-Phen/Redux? | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> X-ray of Cobalt |
| <input type="checkbox"/> Chemotherapy / | <input type="checkbox"/> Heart Disease | Due date: _____ | Treatment |
| Radiation | <input type="checkbox"/> Heart Lesion | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergy: Penicillin |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergy: Latex |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Allergy: Sulfa Drugs |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | | <input type="checkbox"/> Allergy: Ibuprofen |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis A / B | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergy: Tetracycline |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Allergy: Aspirin |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Allergy: Codeine |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Allergy: Epinephrine |
| | | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Allergies: _____ |

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

Σ Have you ever had any complications following dental treatment? Yes No If yes, please explain: _____

Σ Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

Σ Are you now under the care of a physician? Yes No If yes, please explain: _____

Σ **Name of Physician:** _____ **Phone:** _____

Σ Do you have any health problems that need further clarification? Yes No If yes, please explain: _____

In case of emergency, whom shall we call: Name _____ **Relationship** _____

Phone Numbers: _____
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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X _____ Date: _____
Signature of patient, parent or guardian

Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____
Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____
Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____

Responsible Party Information (if different from patient)

Name: _____ Male Female Married Single Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____
Address: _____
Street Apartment # City State Zip Code

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI
Employer Name & Address: _____ Group#: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Phone Number: _____

Secondary Insured Persons Information:

Name: _____ Birth Date _____ ID# _____
Last First MI
Address: _____
Street City State Zip Code
Employer Name & Address: _____ Group#: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name & Phone Number: _____

Consent for Services

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1_% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

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

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

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.

X _____ Date: _____ Relationship to Patient: _____
Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X _____
Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Progressive Dental Arts

X _____
Signature of Responsible Party/Parent or Guardian