

Patient Medical History

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS/ HIV
<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Anaphylaxis
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Breathing Problems
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Chest Pains
<input type="checkbox"/> Cold Sores/ Fever Blisters
<input type="checkbox"/> Congenital Heart Disorder
<input type="checkbox"/> Cortisone Medication
<input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting Spells/ Dizziness
<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart (attack, disease, surgery)
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis A ___ B ___ C ___
<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Latex Sensitivity
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Parathyroid Disease
<input type="checkbox"/> Psychiatric/Psychological Care
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach/ Intestinal Disease
<input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Allergic/ Adverse Reaction to Medication or any Substance?
Please Specify: _____

<input type="checkbox"/> Other medical issues:

_____ |
|---|---|---|---|

Women only: Are you Pregnant?	Yes	No	Nursing?	Yes	No	Taking oral contraceptives?	Yes	No
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- 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: _____
- Have you had any major operation? Yes No
If yes, please explain: _____
- Have you ever had a serious head or neck injury? 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 #: _____
- Are you on a special diet? Yes No
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Please list **all medications**. If you don't have them with you or can't remember, please bring them to your next appointment.

- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
 No Yes _____
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes _____ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist office of any changes in health.

Date: _____

Signature of patient, parent or guardian

Progressive Dental

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Written Financial Policy

It is important that you read this financial policy in full prior to signing.

We require payment of your cost of treatment prior to receiving service.

Payment Options:

You can choose from:

- Cash, Check, MasterCard, American Express, Discover Card, or Visa
- Convenient Monthly Payment Plans from CareCredit, Proceed Finance, & Alpheon
 - Allow you to pay over time
 - No annual fees or pre-payment penalties
 - Interest free plans are available
- Pay as you go. We require payment to reserve your appointment for your next procedure. If partial payment is made, the balance is due upon arrival for treatment.

Important Information Regarding Insurance Coverage and Repayment

Be aware that we recommend and provide treatment based on YOUR specific needs and not what your insurance covers. Treatment recommended is based on the clinical review of Dr. Durr and will always be the best solution for your dental needs. It is the patient's responsibility to know the coverage and limitations of your dental insurance. Insurance will not pay %100 of your treatment. Any amount quoted to be paid by your insurance is an estimate. There is no guarantee of payment by your insurance. Any unpaid amount by your insurance is directly payable by you. There is a high possibility that your insurance will deny or partially cover "covered" procedures. Your insurance can terminate at any time, regardless if we have verified it to be active at the time of service. If this happens, any unpaid amount is to be paid directly by you. If payment is reimbursed to you directly by your insurance company for billed services, you are responsible for repayment to Progressive Dental for the total amount. We provide you with an estimated coverage amount and patient portion after insurance. The patient portion is due at the time treatment is provided. We bill your insurance at time the services are rendered. We do not wait until the insurance pays their estimated portion to us to bill you the difference. It is your responsibility to make us aware of any changes with your coverage.

Appointment Policy

We will try to make several attempts to confirm your appointment through phone and text. If we do not receive a response within 24 hours of your appointment time, we have the right to cancel your appointment. We offer a grace period of 10 minutes for late arrival to your appointment time. We have the right to reschedule your appointment after that time. We request, as a courtesy, that if you are running late, to let our office know ahead of your appointment. A \$50 cancellation fee is charged for patients who miss or cancel an appointment without a 48-hour notice. If an appointment over one hour is cancelled without 48-hour notice, a portion of or the full deposit left for that appointment will be kept and will not be refunded or be available for future use. If an appointment is failed or cancelled without required notice, the amount due for the appointment must be paid in full upon rescheduling. Thank you for understanding.

If you have any questions, please do not hesitate to ask. We are here to help you understand your payment options and any insurance questions you may have. By signing this agreement, you have read and understood the Financial Policy in full. We have the right to refuse treatment if this agreement is not signed.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

(A full copy of the HIPAA notice is available upon request)

I understand my rights of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

I have asked for and received a copy of the HIPAA notice

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

RECORD RELEASE/ RELEASE OF INFORMATION

_____ I authorize Progressive Dental & Associates to disclose my records/ information to the following person(s) upon my consent:

Name: _____ Relation: _____

_____ I do not authorize Progressive Dental & Associates to disclose my records to any persons other than myself.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other: _____

Staff Member Signature

Date