

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: _____
_____ |
|---|---|---|--|

Women only: Are you Pregnant? **Yes** **No** Nursing? **Yes** **No** Taking oral contraceptives? **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: _____
- 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: _____
- Are you taking any medications? Please list: _____

- 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.

Signature of patient, parent or guardian Date: _____

Progressive Dental

20402 CRAWFORD AVE | MATTESON IL, 60443 | (708) 747-4294

Written Financial Policy

Thank you for choosing Progressive Dental. Our primary mission is to deliver the highest quality dental care available in a comfortable environment. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

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

Payment Options:

You can choose from:

- Cash, Check, MasterCard, American Express, Discover Card, or Visa
 - We offer a 3% courtesy discount to patients with no insurance who pay for their full treatment in advance.
- Convenient Monthly Payment Plans from CareCredit and Lending Club
 - Allow you to pay over time
 - No annual fees or pre-payment penalties
 - Interest free plans are available
- Pay as you go. We require a 30% down payment to reserve your appointment for your next procedure, with the balance being due upon arrival for treatment.

Important Information Regarding Insurance Coverage and Repayment

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for 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.** 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 the 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.

Cancellation and Missed Appointment Policy

A \$25 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 hours 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 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.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

***If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. **x-rays taken at a discounted rate (postcards, special offers, etc.) will be subject to standard fees when a copy is requested.**

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