Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____ Birth Date:_____

Social Security #:_____ Driver's License #:_____ State:_____

Phone (Home):_____ (Work):_____ Best time to call:_____

(Cell)_____ E-mail:_____ Fax:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Referral Information

How were you referred to our office? Who may we thank? ◯ Post Card/ Mailer ◯ Our Website ◯ Google/ Internet

◯ Insurance Company:_____ ◯ Other: _____

◯ Another Patient/Friend/ Office: Name_____

Emergency Contact

Name:_____ Relationship:_____

Phone: Home_____ Cell _____

Responsible Party/ Policy Holder Information

Responsible Party/ Policy Holder: _____ Birth Date: _____

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

Phone: Cell _____ Home _____

Insurance Co.:_____ ID #: _____ Group #: _____

Help Us Get To Know You Better

Is there anything about your smile that you do not like?_____

Are you interested in knowing the options available for a more beautiful smile?_____

Do you like the appearance of your teeth?_____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth?_____ Any chipped?_____

Is your bite comfortable when chewing?_____

Do you have any old fillings or dental treatment that you are unhappy with?_____

What would you like to change the most about the appearance of your teeth? _____

Is there anything else you would like us to know?_____

Patient Medical History

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

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

_____

_____

- ☐ 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.

_____ **Date:** _____

Signature of patient, parent or guardian

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 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.

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

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