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? ◯ Post Card/ Mailer ◯ Our Website ◯ Google/ Internet

◯ Insurance Company:__________________________________ ◯ Other: ________________________________

◯ Another Patient/Friend/ Office: Name____

Emergency Contact

Name:____ Relationship:___________________________________

Phone: Home____ Cell ____

Responsible Party for Dependent

Responsible Party ____ Birth Date:____________________________

Address: ______________________________________ City:____________________________ State:____________ Zip Code:__________

Phone: Cell: ____ Home:____

Help Us Get to Know You Better

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

Are you interested in knowing the options available for a more beautiful smile? ◯ Yes ______________________________ ◯ No

Have you been diagnosed or believe you may have sleep apnea? ◯ Yes __________________ ◯ No ◯ Not Sure

Are you or someone you know interested in braces? ◯ Yes ____ ◯ No

Do you have any missing teeth that have been affecting your day to day life such as eating, appearance, or self- esteem?

____

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 medical issues: ____________________________ ____________________________

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

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 and GreenSky
  - 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

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.

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. By signing this agreement, you have read and understood the Financial Policy in full. We have to right to refuse treatment if this agreement is not signed.

____

Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

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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