Progressive Family & Cosmetic Dentistry

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Today's Date: ____________________

PATIENT INFORMATION

How did you learn about our office?(please be specific): ____________________

Patient Name: ____________________ D.O.B.: ____________________

Address: ____________________ **SS#:** ____________________

City/Town: ____________________ State: ________ Zip Code: ____________

Home#: ______________ Work#: ______________ Cell#: ______________ Do you **Text?**: Yes or No

Email Address: ____________________

Have you visited our **Website**? Yes or No Do you have a **Facebook** Account? Yes or No If yes, please "LIKE" us.

DENTAL INSURANCE INFORMATION

Subscriber (Employee) Name: ____________________

D.O.B.: ______________ Subscriber SS#: ____________________

Name of Employer: ____________________ Effective Date Coverage Began: __________

Name of Dental Insurance: ____________________

Group#: ______________ Calendar or Fiscal Year? ____________________

NOTE: ALL INSURANCE INFORMATION MUST BE COMPLETED FOR CLAIM SUBMITTAL. IF WE CAN NOT OBTAIN VERIFICATION OF COVERAGE FOR YOUR APPOINTMENT, YOUR FEES FOR THE VISIT WILL BE DUE AT THE CONCLUSION OF YOUR APPOINTMENT. PLEASE REMEMBER YOUR INSURANCE SHOULD BE CONSIDERED A SUPPLEMENTAL FORM OF PAYMENT…NEVER A PAY ALL FOR TREATMENT. YOU ARE ULTIMATELY RESPONSIBLE FOR ANY TREATMENT RECEIVED. WE WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

PAYMENT INFORMATION

***Acceptable forms of payment:** Cash, Personal Check, Debit/Ck Card, Mastercard, Visa, Discover, American Express or Care Credit*

Please check one of the following:

____ Paying in full at each appointment because I do not have dental insurance or I have an insurance plan that chooses to reimburse me directly.

____ Paying my ESTIMATED CO-PAY at each appointment because my insurance will reimburse Progressive Family & Cosmetic Dentistry directly.

PATIENT AGREEMENT

I understand that I am responsible for all fees incurred for my dental treatment. If I have Insurance I understand that most insurance plans are payment assistance plans, they are not designed to pay all. If I receive any payments from my insurance that were to be paid to the dentist for treatment, I will forward those monies immediately to avoid insurance fraud. I hear by authorize the office of Progressive Dentistry to administer medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care

Patient Signature: ____________________ **Date:** ____________________

Please check one: [] SELF [] PARENT []SPOUSE [] GUARDIAN

ORAL HEALTH ASSESSMENT

Are you having any dental problems that require immediate attention? Yes or No

If yes, please explain: ____________________

When was your last dental visit? Date: __________ What was done?: ____________________

Any treatment recommended? ____________________

How often are you likely to visit your dentist? ____________________

Do you need to **PREMEDICATE** with an antibiotic before dental treatment? Yes or No

How would you describe your past dental care? ____________________

What are your expectations for us? ____________________

Have you ever been told by a prior dentist/hygienist that you have Periodontal [gum] Disease? Yes or No

If yes, explain: ____________________

What type of toothbrush do you use? ____________________

How many times a day do you BRUSH? ____ FLOSS? ____ RINSE? ____ IRRIGATE? ____

Have you ever worn an appliance for your bite or jaw joint? Yes or No If yes, when & type? ____________________

MEDICAL REVIEW

Physician's Name: ____________________ Phone#: ____________________

Medical Insurance: ____________________ ID#__________ G#__________

In the last 2 years have you been hospitalized or in the care of your physician? Yes or No

Have you ever had **MAJOR** surgery? Yes or No

Have you ever had a serious **head, neck or mouth** injury or operation? Yes or No

Have you ever been treated for **heart disease or vascular disease**, such as a heart attack, coronary artery disease, heart murmur, defective heart valve, high/low blood pressure? Yes or No

Do you have an **irregular heartbeat or pacemaker**? Yes or No

Do you have **shortness or breath, ankle swelling or chest pain upon exertion**? Yes or No

Have you ever had **Rheumatic Fever**? Yes or No

Have you ever had any **blood disorders**, such as **anemia or leukemia**? Yes or No

Do you **bruise easily**? Yes or No

Are you **excessively thirsty**? Yes or No

Do you have **Diabetes** or any **Blood Sugar problems**? Yes or No

Have you ever had any type of **Cancer**? Yes or No

Are you **allergic to latex**? Yes or No

Do you have any **other allergies**? Yes or No

Do you smoke? Yes or No or Quit

Have you ever had any **respiratory problems**, such as **chronic sinusitis, lung disease, asthma, emphysema, tuberculosis**? Yes or No

Have you ever had **Hepatitis**? Yes or No

Have you ever had a **sexually transmitted disease**? Yes or No

Do you have **mood swings, depression or anxiety**? Yes or No

Do you get **frequent headaches or migraines**? Yes or No

Do you suffer from **frequent cold sores or mouth ulcers**? Yes or No

Do you have any **skeletomuscle problems** such as **arthritis, osteoporosis, muscle disease, prosthetic joint, back or neck** problems? Yes or No

Have you ever had **stomach ulcers or colitis**? Yes or No

Do you have **thyroid, liver or kidney disease**? Yes or No

Do you have any **stress management issues** (physical, mental, emotional, physiological, nutritional or social)? Yes or No

Do you have any history of **substance abuse**? Yes or No

Do you have any impairments with **vision, hearing, speech, dexterity or mobility**? Yes or No

Do you have a **fluoridated water supply** ? Yes or No

Do you have any **sleep disorders** such as **snoring, sleep apnea, insomnia**? Yes or No

FOR WOMEN: Are you **pregnant, nursing or on birth control**? Yes or No Do you take **Hormone Replacement Therapy**? Yes or No

PLEASE LIST ALL MEDICATIONS (OTC, Prescription, Holistic) ____________________

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