

ENTERED BY: _____

PROGRESSIVE DENTAL, PLLC

Patient Information

Patient Name: _____ Birth Date _____
Last First MI

Who may we thank for referring you? Phone book Location Reputation Friend Other _____

Health Information

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anti-Depressant _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |

- What was the reason you left your last dentist? _____
- Date of Last Dental Visit: _____ Reason for this visit: _____
- What medications are you currently taking? _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems or any previous surgeries that need further clarification? Yes No
If yes, please explain: _____
- Have you ever been told that you need to pre-medicate before a dental visit _____

Our office requires payment at the time service is rendered

Payment can be made by: Cash/Check Credit Card American Gen.

- I authorize payment of insurance benefits, otherwise payable to me, directly to the treating doctor. My signature is a file signature for dental insurance.
- I understand that I am responsible for all fees regardless of insurance coverage.
- I authorize **Progressive Dental, pllc** to verify my past and present credit references.
- Any unpaid balance remaining after 60 days will be assessed a monthly 1.5% interest. If a balance remains unpaid for 90 days, and collection action is necessary, I will be responsible for all collection and attorney fees incurred.
- I authorize **Progressive Dental, pllc** to send my recall cards through the mail, leave messages confirming my appointments on my answering machine, contact any dentist for medically necessary information, and remind, if necessary, to pre-medicate.

To the best of my knowledge, all of the preceding answers and information provided is true and correct. If I ever have any change in my health I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Doctor's Signature Date: _____