progressive™ dental

it's personal

ENTERED BY: _____

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:

☐ HIV
☐ Allergies _____
   _____
☐ Anemia
☐ Anti-Depressant_____
☐ Arthritis
☐ Joint Replacement
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders

☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Defibrillator
☐ **Currently Pregnant**
   Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizure
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke

☐ Thyroid Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____

☐ _____

- 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   CareCredit   Wells Fargo

- 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.
- **Progressive Dental, pllc** reserves the right to verify my past and present credit references.
- 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.

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