Thank you for selecting our office. We will strive to provide you with the best possible dental care. To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please let us know.

WELCOME TO OUR PRACTICE.

PATIENT INFORMATION (Confidential) **Email Address_____@_____**

Name _____ ❑ Male ❑ Female Birthdate_____ SS#_____

Address_____ City_____ State_____ Zip_____

Phone_____ ❑ Home ❑ Cell Best Phone Number to Contact You_____

Employer_____ Bus Phone_____

❑ Minor ❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Separated Spouse/Parent Name _____

Whom may we thank for referring you?_____

Person to Contact in Case of Emergency_____ Phone_____

How Do You Prefer to Be Contacted for Appointment Reminders? ❑ Best Phone Number Provided

❑ Email Provided ❑ Text Message

We would greatly appreciate you responding to our reminders. Thank you

RESPONSIBLE PARTY

Person Responsible for Account_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Phone_____ ❑Home ❑Cell Best Phone Number to Contact Them_____

Birthdate_____ SS#_____

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____ SS#_____

Employer_____ Date Employed_____ Birthdate_____

Name of Insurance_____ Group/Policy #_____

DO YOU HAVE SECONDARY INSURANCE ❑Yes ❑No If yes, please complete the following:

Name of Insured_____ Relationship to Patient_____ SS#_____

Employer_____ Date Employed_____ Birthdate_____

Name of Insurance_____ Group/Policy #_____

I certify that I have read and understand, to the best of my knowledge, the information listed. The medical questions have been accurately answered. I also consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I agree to accept full responsibility for the payment of all fees associated with those procedures or drugs associated with the performance of those procedures. I acknowledge that I am ultimately responsible for the full payment of all such fees and charges. **I acknowledge that payment is due in full at the time of service. I understand there is a 48-hour cancellation policy to avoid missed appointment charges.**

Patient's Signature _____ Date _____

Doctor's Signature _____

Joseph D. Bedich, DDS, MAGD
The Center For Progressive Dentistry
PATIENT MEDICAL HISTORY

Name of Physician_____ Date of Last Visit_____

1. Are you currently under medical treatment? ..... Y/N
   If yes please explain_____
2. Have you been hospitalized for any surgical operation or illness in the last 10 years? ..... Y/N
   If yes please explain_____
3. Do you use any type of tobacco? ..... Y/N
   If yes what kind and how much_____
4. Do you use any controlled substances? ..... Y/N
   If yes please explain_____
5. Do you use any recreational drugs? ..... Y/N
   If yes please explain_____
6. Do you drink alcohol? ..... Y/N
   If yes how much per week_____
7. Have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonates? ..... Y/N
   If yes what kind, how much, and how long_____
8. Do you or have you been told you snore at night? ..... Y/N
9. Have you been diagnosed with Sleep Apnea? ..... Y/N
   If yes do you wear a CPAP at night ..... Y/N
10. Do you get headaches or migraines ..... Y/N
    If yes what type and how often_____

Women Only Questions 11 & 12

11. Are you pregnant or trying to get pregnant? ..... Y/N
12. Are you taking oral contraceptives? ..... Y/N
13. Are you allergic to or had a reaction to the following?:

Local Anesthesia (Novocaine)	Y/N	Codeine	Y/N
Penicillin	Y/N	Iodine	Y/N
Sulfa Drugs	Y/N	Latex	Y/N
Other Antibiotics	Y/N	Valium or other sedatives	Y/N
Aspirin	Y/N	Other_____	Y/N
Other_____	Y/N	Other_____	Y/N

14. Do you have or have you had any of the following?

Chest Pains (Angina)..... Y/N	Diabetes..... Y/N	Cancer..... Y/N
Heart Disease (Failure). Y/N	Low Blood Sugar..... Y/N	Tumors/Growths..... Y/N
Heart Attack..... Y/N	Excessive Thirst..... Y/N	Radiation Therapy ..... Y/N
Heart Surgery..... Y/N	Frequent Urination..... Y/N	Chemotherapy ..... Y/N
Heart Valve Replace ..... Y/N	Kidney Dis/Dialysis..... Y/N	Stomach Problems ..... Y/N
Cardiac Pacemaker ..... Y/N	Epilepsy/Seizures..... Y/N	Ulcers..... Y/N
Heart Murmur..... Y/N	Join Replacement ..... Y/N	Crohn's Disease ..... Y/N
Mitral Valve Prolapse..... Y/N	Arthritis..... Y/N	Ulcerative Colitis..... Y/N
Rheumatic Fever..... Y/N	Osteoporosis ..... Y/N	Thyroid Problems ..... Y/N
Rheumatic Heart Dis ..... Y/N	Blood Diseases..... Y/N	Thyroid Disease ..... Y/N
High Blood Pressure..... Y/N	Anemia..... Y/N	Recent Weigh Loss..... Y/N
Low Blood Pressure ..... Y/N	Factor 5 (Liden Dis) .... Y/N	Psychiatric Care ..... Y/N
Stroke..... Y/N	Bruise Easily..... Y/N	Sex Transmit Disease..... Y/N
Swollen Ankles ..... Y/N	Excessive Bleeding ..... Y/N	HIV Infection/AIDS..... Y/N
Sinus Problems..... Y/N	Blood Transfusions ..... Y/N	Cold Sores/Fever Blister ..... Y/N
Asthma ..... Y/N	Leukemia ..... Y/N	Organ Transplants ..... Y/N
Shortness of Breath ..... Y/N	Jaundice..... Y/N	TMJ..... Y/N
Frequent Coughing ..... Y/N	Hepatitis A..... Y/N	Headaches/Migraines..... Y/N
Emphysema/COPD ..... Y/N	Hepatitis B or C ..... Y/N	Other_____
Easily Winded ..... Y/N	Liver Disease..... Y/N	Other_____
Resp/Lung Problems ..... Y/N	Eye Problems ..... Y/N	Other_____
Tuberculosis/TB..... Y/N	Glaucoma ..... Y/N	Other_____

Please list any Medications, Dietary Supplements and/or Herbal Medications you are taking at this time.

Medication/Strength/x Day	Reason for Taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

THE CENTER FOR
PROGRESSIVE
DENTISTRY
Implant, Cosmetic, Sedation and Family Dentistry

Financial Arrangements
In an effort to hold the line on dental costs while maintaining a superior level of professional care we have established the following payment options:

- Payment is expected at time of service, at which time you will receive a 5 % discount for payments paid in full when paying cash.
- Our Financial Secretary will help you with processing credit card payments. We accept Visa/MasterCard/Discover/American Express.
- Outside financing is available with Care Credit and Lending Club upon approval.
- A $10 billing charge will be added to all past due statements over 40 days.
- You will be presented with the cost of your treatment before the work is performed so that clear financial arrangements can be made.
- Because dental laboratories require prompt payment from us, a down payment from you is necessary to offset our "upfront" expenses. This down payment is to be paid on the day of the final impression for extensive treatment. This includes any and all work that will need to be performed by the dental labs we work with for your treatment.
- We will be sensitive to your financial circumstances within the framework of sound business practices. We want to be concerned with your dentistry, not financial responsibilities.

A Word About Dental Insurance
We participate in nearly all bonafide dental insurance plans and are eager to help you with your claims. However, we are not providers for Medicare/Medicaid. In this regard we would like to offer the following tips:

- Our office will accept your insurance once it has been verified. Verification usually occurs before your first visit. Patients who have insurance that cannot be verified before their visit will be consider self-paying patients. We will submit your claim once your insurance information has been verified. Please make sure the information you are giving us is correct and complete.
- Take advantage of the pre-treatment estimate feature for the more extensive dental care. Your insurer will provide us with the amount that they will cover in advance of extensive treatment. We will then determine your estimated co-payment portion.
- We are glad to file your insurance for you. However, please remember that your insurance is a contract between you and your employer. The Center For Progressive Dentistry has nothing to do with what is covered. If your insurance does not pay your claim in 40 days, you will be responsible for the balance.
- In the event of a cancellation of a sedation or surgical appointment with less than a 48 hour notice, a non-refundable deposit will be applied for the missed appointment.
- The adult who presents a minor for dental care will be considered the responsible party for payment at time of service.

I understand and acknowledge the above policies of The Center For Progressive Dentistry

Name _____ Date_____