

# The Center For Progressive Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs. Please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## **Patient Information** (CONFIDENTIAL)

Name \_\_\_\_\_  Male  Female Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Check appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_ Spouse/Parent Name \_\_\_\_\_  
 If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
 Whom May We Thank for Referring You? \_\_\_\_\_ Email \_\_\_\_\_  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## **Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Payment is due in full at time of services. For your convenience we accept Cash, Personal Checks, and Major Credit Cards.

## **Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Insurance \_\_\_\_\_ Group or Policy # \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Insurance \_\_\_\_\_ Group or Policy # \_\_\_\_\_

## **Patient Dental Information**

	YES	NO		YES	NO
1. Are you having any discomfort at this time? .....	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever had any difficulty with		
2. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	extractions.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had your teeth straightened? ...	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever experienced any of the following problems			7. Do you use dental floss? .....	<input type="checkbox"/>	<input type="checkbox"/>
in your jaw? Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have any fear of having dentistry done? .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face) .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/>	<input type="checkbox"/>	10. If yes are you satisfied with them? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Medical History**

Name of Physician \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
|   | YES                      | NO                       |  | YES                      | NO                       |
| 1. Are you under medical treatment now? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to or have had reactions to the following? |                          |                          |
| 2. Have ever been hospitalized for any surgical operation or serious illness in the last 5 years? ..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. Novocaine) .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please explain _____  |                          |                          | Penicillin or any other Antibiotics .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Sulfa Drugs .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use tobacco? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, how much _____  |                          |                          | Valium or Other Sedatives .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use controlled substances? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Codeine .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Women Only:  |                          |                          | Aspirin .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant or think you may be pregnant? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Iodine .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking oral contraceptives? .....   | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Other (please list) _____                                      |                          |                          |

- |  |                          |                          |                            |                          |                               |                          |
|--|--------------------------|--------------------------|----------------------------|--------------------------|-------------------------------|--------------------------|
| 6. Do you have or have you had any of the following? | YES                      | NO                       | YES                        | NO                       | YES                           | NO                       |
| Heart Murmur .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker .....    | <input type="checkbox"/> | Chest Pains .....             | <input type="checkbox"/> |
| Mirtal Valve Prolapse .....                          | <input type="checkbox"/> | <input type="checkbox"/> | Angina .....               | <input type="checkbox"/> | Easily Winded .....           | <input type="checkbox"/> |
| Heart Attack .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | Stroke .....               | <input type="checkbox"/> | Hay Fever/Allergies .....     | <input type="checkbox"/> |
| Rheumatic Heart Disease .....                        | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem .....      | <input type="checkbox"/> | Tuberculosis .....            | <input type="checkbox"/> |
| Rheumatic Fever .....                                | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems ..... | <input type="checkbox"/> | Glaucoma .....                | <input type="checkbox"/> |
| Joint Replacement .....                              | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions .....   | <input type="checkbox"/> | Recent Weight Loss .....      | <input type="checkbox"/> |
| High Blood Pressure .....                            | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder .....       | <input type="checkbox"/> | Psychiatric Care .....        | <input type="checkbox"/> |
| Low Blood Pressure .....                             | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice .....             | <input type="checkbox"/> | Sexually Trans. Disease ..... | <input type="checkbox"/> |
| Asthma .....   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis .....            | <input type="checkbox"/> | AIDS or HIV Infection .....   | <input type="checkbox"/> |
| Fainting/Seizures .....                              | <input type="checkbox"/> | <input type="checkbox"/> | Cancer .....               | <input type="checkbox"/> | Stomach Problems/Ulcers ..... | <input type="checkbox"/> |
| Epilepsy .....                                       | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy .....    | <input type="checkbox"/> | Kidney Diseases .....         | <input type="checkbox"/> |
| Swollen Ankles .....                                 | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy .....         | <input type="checkbox"/> | Organ Transplants .....       | <input type="checkbox"/> |
| Diabetes .....                                       | <input type="checkbox"/> | <input type="checkbox"/> | Anemia .....               | <input type="checkbox"/> | Other _____                   |                          |

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

Medication/Strength/Times Per Day	Reason For Taking	Medication/Strength/Times Per Day	Reason For Taking

**Authorization For Treatment and Promise of Payment**

I certify that I have read and understand, to the best of my knowledge, the above information. The above 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. In the event that my Insurance Carrier fails to make payment, I acknowledge that I am ultimately responsible for the full payment of all such fees and charges. **I further acknowledge that payment in full is due at the time of the service. We require 24 hours notice when cancelling an appointment to avoid a missed appointment charge.**

**X** \_\_\_\_\_  
Signature of patient (or parent if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date