Progressive Dental Group (Dr. Alda Underwood-Hall) 2485 Park Central Blvd, Suite 3 Decatur, GA 30035

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL.)

Date_____

Patient'sName_____DOB_____☐Male☐Female
Last First Middle Initial

Address_____ _____
Street Number City Zip

Patient is: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Minor

Driver's License No. _____ Social Security No._____ Res. Phone ( ) _____

Cell Phone No. ( ) _____ E. Mail _____

Employer _____How Long? _____ Occupation _____

Business Address _____Business Phone No ( ) _____

Spouse's Name _____Drivers License No._____ Social Security No_____

Employer _____How Long? _____ Occupation _____

Business Address _____Business Phone No ( ) _____

Name of Physician _____ Physician Phone ( ) _____

Former Dentist _____ Dentist Phone ( ) _____
Address City Zip

Purpose of Appointment _____

Whom may we thank for referring you to our office? _____

FINANCIAL INFORMATION

Insurance Name _____Subscriber ID#_____

Name of Primary Policy Holder_____ SS# _____

Policy Holder Date of Birth _____ Full Time Student (Yes or No) Name of School _____

TERMS & CONDITIONS

We at Progressive Dental Group are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available today. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made. All balances over 90 days will be charged a rebilling fee of $5.29 for each billing cycle until balance is paid in full. As a courtesy to all of our insurance patients you should understand that your estimated co-pay must be paid at the time of service. We will do our best to give you a rough estimate of your out of pocket expense for each upcoming visit, based on your individual treatment plan. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan. We can never guarantee coverage and payment for any services provided by our office. Not all services are covered benefits in all contracts and some insurance companies arbitrarily select certain services they will or will not cover. Whatever your insurance company does not cover to avoid a $5.29 rebilling fee you have 21 days to pay your balance (if any) from the date of your billing statement. If you are unsure of your coverage benefits, and have questions regarding non-covered procedures call the customer service number on your insurance card. **Your Dental Appointments are scheduled carefully.** Time, trained personnel prepare for your procedures 24 hours in advance. Missed and broken appointments add to the cost of dental care. Our professionals call to confirm your appointments 48 hours in advance. If you are unable to keep your appointment it is very important that you call us within 48 hours and reschedule to avoid being charged a missed or broken appointment fee of $33. If frequent missed and/or broken appointments occur, a credit card reservation fee of $75 will be required to reserve your next appointment which is refundable or may be applied to your co-pay. Additionally, I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees. I grant my permission to you, or your assignee, to telephone me at home or my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content:

Signature_____Date_____

PLEASE TURN OVER AND COMPLETE THE BACK

HEALTH QUESTIONNAIRE

These questions are for your benefit and to assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question. Check the appropriate box Yes or No where applicable.

MEDICAL HISTORY

1. Are you in good health? ……..☐Yes ☐No
2. Date of last physical examination. _____
3. Are you under the care of a physician now? ……☐Yes ☐No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ……...☐Yes ☐No
   If so, what illness or operation? _____
5. Are you taking any medications? ……..☐Yes ☐No
   If so, what? _____

   _____
6. Are you using any recreational drugs (marijuana, cocaine, etc)? .....☐Yes ☐No
7. Have you ever been pre-medicated with antibiotics for dental treatment? ……..☐Yes ☐No
8. Are you sensitive or allergic to any drugs or materials? ☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin

   ☐Codeine ☐Latex ☐Other If other, what drugs? _____

10. Do you have or have you had any of the following: (Please select Y for Yes or N for No- answer all conditions):

Y/N Anemia	Y/N Hemophilia	Y/N Heart Murmur	Y/N Tuberculosis	Y/N Cortisone Medicine	Y/N Heart Attack
Y/N Herpes	Y/ N Cold Sores	Y/N Liver Disease	Y/N Blood Transfusion	Y/N Allergies to Metals	Y/N Mitral-Valve Prolapse
Y/N Stroke	Y/ N Emphysema	Y/N Blood Disease	Y/N Joint Replacement	Y/N Excessive Bleeding	Y/N X-Ray or Cobalt TX
Y/ N Ulcers	Y/ N Chicken Pox	Y/N Drug Addition	Y/N Nervous Disorder	Y/N High Blood Pressure	Y/N Chemotherapy
Y/ N Diabetes	Y/ N Bruise Easily	Y/N Kidney Disease	Y/N Tumors or Growths	Y/N HIV Related Complex	Y/N Radiation Treatment
Y/ N Arthritis	Y/ N Head Injuries	Y/N Stomach Ulcers	Y/N Allergies or Hives	Y/N Respiratory Disease	Y/N Venereal Disease
Y/ N Hay Fever	Y/N Heart Failure	Y/N Angina Pectoris	Y/N Pain in Jaw	Y/N Epilepsy or Seizures	Y/N HIV/AIDS
Y/N Tonsillitis	Y/ N Scarlet Fever	Y/N Mental Disorder	Y/N Rheumatic Fever	Y/N Psychiatric Treatment	Y/N TMJ
Y/N Asthma	Y/ N Rheumatism	Y/N Cerebral Palsy	Y/N Artificial Prosthesis	Y/N Hepatitis	Y/N Others: _____
Y/ N Glaucoma	Y/ N Sinus Trouble	Y/N Thyroid Disease	Y/N Sickle Cell Disease	Y/N Difficulty Swallowing	Y/N Pacemaker
Y/N Back Problems	Y/N Artificial Heart Valves	Y/N Circulatory Problems	Y/N Cough up Blood	Y/N Persistent Cough	

11. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... ☐Yes ☐No
12. Do you have any disease, condition or problem not listed that you think we should know about? ……..☐Yes ☐No
    If so, what? _____
13. Do you smoke? If yes, what and how much? _____☐Yes ☐No
14. Have you ever take the drug “Phen-Phen” or “Redux”? ……...☐Yes ☐No
15. (Women) Are you pregnant? If so, how many months? _____.....☐Yes ☐No
16. (Women) Do you take birth control pills? ……☐Yes ☐No

DENTAL HISTORY

1. Have you ever had any unfavorable reaction from a local anesthetic, nitrous oxide, or general anesthetic? ☐Yes ☐No

2. Have you had any serious trouble associated with any previous dental treatment? ..... ☐Yes ☐No
   If so, please explain? _____
3. How long since your last full mouth X-Rays? _____
4. How long since your last dental visit? _____
5. When was your last dental cleaning? _____

6. Does dental treatment make you nervous? ..... ☐Yes ☐No

7. Do you have an existing partial? ..... ☐Yes ☐No

8. Do you have pain in or jaw or near your ears? ..... ☐Yes ☐No

9. Do you experience severe or frequent headaches? ..... ☐Yes ☐No

10. Do you have any inflamed areas in or around your mouth? ..... ☐Yes ☐No

11. Have you had any current or previous injury to your mouth? ..... ☐Yes ☐No

12. Have you experience any growths or sore spots in your mouth? ..... ☐Yes ☐No

13. Does any part of your mouth hurt when clenching? ..... ☐Yes ☐No

14. Do your gums bleed? ..... ☐Yes ☐No

15. Do you have any bad tastes or odors in you mouth? ..... ☐Yes ☐No

16. Have you ever been told you have problems with your gums? ..... ☐Yes ☐No

17. Have you ever had treatment related to gum problems? ..... ☐Yes ☐No

18. Have you ever had braces? When_____ For how long_____..... ☐Yes ☐No

19. Do you clench or grind your teeth (day or night)? ..... ☐Yes ☐No

20. Do you snore? ..... ☐Yes ☐No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.
All Services are rendered and accepted under the terms and conditions printed on the reverse hereof:
Authorization must be signed by the patient, or by the legal guardian in the case of a minor or when the patient is physically or mentally incompetent.

Signature_____ Today's Date: _____