PROGRESSIVE PERIODONTICS

105 Carnegie Place • Suite 113 • Fayetteville, GA 30214
Phone 678-817-0600 • FAX 678-817-0601

PERSONAL & CONFIDENTIAL INFORMATION

Nickname _____ Date of Birth _____

Name _____ Age _____ Sex _____ SSN# _____

Street _____ City _____ Zip _____ County _____

Home Phone _____ Alternate Phone _____

Nearest relative not living with you _____ Relationship _____ Phone _____

Employer _____ Phone _____

Spouse _____ Phone _____

Person responsible for fees _____ DOB _____ SS# _____

Referred by _____ Have X-rays been sent _____

Have any of your relatives been treated by us _____ Drivers License #_____

MEDICAL HISTORY (Please Read and Answer Carefully)

Do you smoke?	☐ Yes	☐ No
Have you ever had orthodontics?	☐ Yes	☐ No
Are you allergic or sensitive to any medicines?	☐ Yes	☐ No
Are you allergic to Penicillin?	☐ Yes	☐ No
Are you under the care of a Physician now?	☐ Yes	☐ No
Have you been treated by a Physician recently?	☐ Yes	☐ No
Have you ever been admitted to the hospital?	☐ Yes	☐ No
Are you taking any medicines now?	☐ Yes	☐ No
Are you Pregnant?	☐ Yes	☐ No

Name of Orthodontist _____

List the medicines you are allergic to:

_____

_____

List the medicines you are taking:

_____

_____

Please Circle Any of the Following Which You Have Had: (If none, circle NONE), and sign in Space Below

Arthritis	Seizures	Glaucoma	Problems with tooth extractions
Heart Trouble	AIDS	Hepatitis	Thyroid Problems
Heart Murmur	Difficulty Breathing	Bleeding Problems	Malignancy
Rheumatic Fever	Lung Trouble	Nervous Problems	NONE
High Blood Pressure	Liver Trouble	Diabetes	
Low Blood Pressure	Jaundice	Asthma	
Anemia	Kidney Trouble	Peptic or Stomach Ulcers	

BP _____ Pulse _____ Wgt. _____

FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED

Please indicate method of payment desired: ☐ Cash ☐ Check ☐ Charge Card

Insurance: Dental ☐ Yes ☐ No Medical ☐ Yes ☐ No

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. **It is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees or court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature: _____

I certify that I have read and answered the above questions correctly. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Dr. Russell, or any other member of her staff responsible for any errors or omissions that I have made upon completion of this form.

Patient's signature (or parent if patient is a minor) _____ Date _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

General Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

Do either of your parents wear dentures? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? **Yes No**

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	**Yes No**
Sweets?	**Yes No**
Biting or Chewing?	**Yes No**
Have you noticed any mouth odors or bad tastes?	**Yes No**
Do you frequently get cold sores, blisters or any other oral lesions?	**Yes No**

Do your gums bleed or hurt? **Yes No**

Have your parents experienced gum disease or tooth loss?	**Yes No**
Have you noticed any loose teeth or change in your bite?	**Yes No**
Does food tend to become caught in between your teeth?	**Yes No**

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	**Yes No**
Bite your lips or cheeks regularly?	**Yes No**
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	**Yes No**
Mouth breathe while awake or asleep?	**Yes No**
Have tired jaws, especially in the morning?	**Yes No**
Smoke/chew tobacco?	**Yes No**

Have you ever had:

Orthodontic treatment?	**Yes No**
Oral surgery?	**Yes No**
Periodontal treatment?	**Yes No**
Your teeth ground or the bite adjusted?	**Yes No**
A bite plate or mouth guard?	**Yes No**
A serious injury to the mouth or head?	**Yes No**

If so, please describe, including cause ____

_____

Have you experienced:

Clicking or popping of the jaw?	**Yes No**
Pain? (joint, ear, side of face)	
Difficulty in opening or closing the mouth?	**Yes No**
Difficulty in chewing on either side of the mouth?	**Yes No**
Headaches, neckaches or shoulder aches?	**Yes No**
Sore muscles (neck, shoulders)?	**Yes No**

Are you satisfied with your teeth's appearance?	**Yes No**
Would you like to keep all of your teeth all of your life?	**Yes No**
Do you feel nervous abut having dental treatment?	**Yes No**

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? **Yes No**

If yes, please describe

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
(Street, City, State, Zip Code)

insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
(Street, City, State, Zip Code)

insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and address: _____