

# Progressive-Dentistry, LLC

Your Option ~ Your Choice

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## PATIENT ACQUAINTANCE FORM

Patient's Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Cellphone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Sex: \_\_\_\_\_ Birthdate/Birthplace \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_  
If a child, parent's name \_\_\_\_\_  
*In Case of Emergency, Notified:* \_\_\_\_\_ *Contact #:* \_\_\_\_\_

### PRIMARY DENTAL INSURANCE INFORMATION:

Name of Policy Subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Phone #: \_\_\_\_\_ Ins. Co Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Subscriber's Soc. Sec. #: \_\_\_\_\_ Group #: \_\_\_\_\_ Ins. Co Phone #: \_\_\_\_\_

**PLEASE GIVE SECONDARY INSURANCE INFORMATION TO OUR RECEPTIONIST.**

How were you referred to our practice? \_\_\_\_\_  
Are you here for a short term fix or a long term solution? \_\_\_\_\_

**Yes No**

- \_\_\_\_\_ 1. Do you have any dental conditions requiring treatment today?
- \_\_\_\_\_ 2. Have you been treated by a physician within the past year?
- \_\_\_\_\_ 3. Has there been any change in your health in the past year?
- \_\_\_\_\_ 4. Are you allergic to any medications? Please list: \_\_\_\_\_
- \_\_\_\_\_ 5. Has any physician or dentist asked you to take an antibiotic just prior to your dental visit?

### Does Your Medical History Include Any of the Following Conditions? (Check/Circle which applies)

- |                                                                                   |                             |
|-----------------------------------------------------------------------------------|-----------------------------|
| _____ Surgical procedures, including cosmetic procedures, within the last 5 years | _____ Tuberculosis          |
| _____ Rheumatic Fever                                                             | _____ Ulcers                |
| _____ Heart Murmur/ Mitral Valve Prolapse                                         | _____ Rheumatism            |
| _____ Heart Attack/ Heart surgery/ Pacemaker                                      | _____ Arthritis             |
| _____ Artificial Valves                                                           | _____ Stroke                |
| _____ High or Low Blood Pressure                                                  | _____ Dizziness             |
| _____ Respiratory Disease/Asthma                                                  | _____ Epilepsy              |
| _____ Diabetes                                                                    | _____ Fainting Episodes     |
| _____ Tumors/Growths/ Cancer                                                      | _____ Head Trauma/Disorders |
| _____ Radiation or Chemotherapy                                                   | _____ Mental Disorders      |
| _____ Bleeding or Anemia problems                                                 | _____ Jaw Problems TMJ/TMD  |
| _____ Other blood disorders? If so, please list. _____                            |                             |

**(Medical History Continued – Please check/circle which applies)**

- |                                                              |                                                                 |
|--------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Artificial bones/joint replacements | <input type="checkbox"/> Stomach or Intestinal Disease          |
| <input type="checkbox"/> Sinus problems                      | <input type="checkbox"/> Venereal Disease/ Herpes/ Canker sores |
| <input type="checkbox"/> Thyroid disease                     | <input type="checkbox"/> Hepatitis A, B or C                    |
| <input type="checkbox"/> Liver disease                       | <input type="checkbox"/> HIV, AIDS or AIDS Related Syndrome     |
| <input type="checkbox"/> Kidney disease                      | <input type="checkbox"/> Are you pregnant or nursing?           |
| <input type="checkbox"/> Do you smoke? _____                 | <input type="checkbox"/> Do you drink alcohol? _____            |
| If so, how much per day? _____                               | If so, how much per day? _____                                  |

**Dental Questions:**

- \_\_\_\_\_ 1. Have you ever had a complete series of dental x-rays (approx. 20) taken?  
    If so, when? \_\_\_\_\_ by whom? \_\_\_\_\_ may we obtain them? \_\_\_\_\_
- \_\_\_\_\_ 2. Have you ever had a severe toothache?
- \_\_\_\_\_ 3. Have you ever had treatment for your gums?
- \_\_\_\_\_ 4. Do you want to improve the appearance of your teeth?
- \_\_\_\_\_ 5. Do your gums bleed or hurt when you brush them?
- \_\_\_\_\_ 6. Have you been aware of any bad odor or taste in you mouth?
- \_\_\_\_\_ 7. Are your teeth sensitive to heat, cold, or sweets?
- \_\_\_\_\_ 8. Do any of your teeth hurt when you chew?
- \_\_\_\_\_ 9. Have your teeth moved or drifted from their normal position?
- \_\_\_\_\_ 10. Do you grind or clench your teeth during the day, or night?
- \_\_\_\_\_ 11. Do you ever get pain in the jaw joint or frequent headaches?
- \_\_\_\_\_ 12. Have you ever noticed popping or clicking in your jaw joint?
- \_\_\_\_\_ 13. Do you consent to diagnostic photographs (X-rays)?

**List Any Drugs/Medications/Supplements That You Are Presently Taking:**

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**A Message About Our Practice**

We have been serving the dental needs of our patients since 1990. We take great care in offering individualized treatment. The entire staff works in harmony to complement the needs of our patients while establishing a relationship of trust, ensuring a pleasant experience.

**We would like to introduce you to our staff:** As our practice grows, additional staff join us to help serve your needs. Since, we all work together utilizing our special skills, through the course of your dental care you may interact with:

- Jeffrey Oras, D.M.D - General Dentist
- Marie Oras – Office Manager/Dental Assistant
- Kristin Guarino - Dental Assistant
- Jean Evers, R.D.H. - Dental Hygienist
- Ashley Morin, R.D.H. – Dental Hygienist
- Beverly Ricci – Practice Administrator

If there are any concerns, questions, or comments that you have while in the practice please let us know so we may help meet your expectations.

## **Our Financial Policy:**

Payment is expected at the time services are rendered, unless prior arrangements have been made.

Billing statements are sent out monthly. Our office reserves the right to charge balances older than 60 days a finance charge at the rate of 1.5% per month (18% annually). Additionally, our office reserves the right to charge returned check fees and charge for broken appointments cancelled without 24 hour advance notice.

In order to make payment for services, as convenient as possible, we offer three payment options:

- 1) Cash, Check or Credit Card (Mastercard / Visa / Discover / AMEX).
- 2) For non-dental insurance patients, a 5% fee reduction, **on complex cases**, when paid in advance by cash, check or credit card.
- 3) Care Credit: a flexible, monthly payment plan, which offers either a no interest or low interest (9.9%) plan with no down payment, no annual fees or prepayment penalties. (Application or information available at our front desk.)

**Other financial options can be discussed based on the complexity of the treatment plan.**

## **For Those Patients With Insurance:**

As a courtesy, our office will promptly submit all claim forms. Insurance coverage is not a substitute for our professional fees, therefore, anything not covered by the insurance is ultimately the patient's responsibility. Some insurance carriers will not reimburse our office directly. In those cases, we expect payment in full for services when they are rendered. We will then submit claims immediately for reimbursement directly to the patient.

Upon your signature of this form, our office will accept an assignment of benefits from your insurance company with the following provisions:

- The estimated portion not covered by the insurance, co-payment and/or deductible, be paid at the time of service.
- If your insurance company pays more than the balance due, we will promptly refund that money to you, or with your permission, apply this credit to your account.
- If your insurance payment is not received within 60 days from the time of billing, we ask that you pay the balance due and seek reimbursement from your insurance company.
- We will provide the necessary documentation your insurance company requests to process all dental claims. However, we will not enter into a dispute with your insurance company over any claim.
- We do not guarantee that your insurance company will pay for any treatment that you receive from our office.
- We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

We are committed to providing you with the best possible dental care, using the highest quality dental materials, making your visit the most positive experience in dental care

## **Responsible Party**

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Signature \_\_\_\_\_ Date \_\_\_\_\_