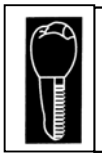

implant, esthetic &
reconstructive dentistry

KEITH PROGEBIN, D.D.S., P.L.L.C.

Patient Information

Date _____

Last Name _____

First Name _____ M.I. _____

Preferred Name (Nickname) _____

Address _____

City _____

State _____ Zip _____

Home Phone (_____) _____

Work Phone (_____) _____ Ext_____

Cell Phone (_____) _____

E-mail _____

Best way to contact you:

Preferred Pronoun: Sex:

How would you like to be addressed? _____

Birthdate _____

Single ☐ Married ☐ Minor ☐ Widowed ☐

Separated ☐ Divorced ☐

Social Security # * _____

* Required for insurance purposes only

Patient Employment Information

Occupation _____

Employer _____

Business Address _____

_____

Whom may we thank for referring you? _____

Business Phone (_____) _____

Primary Dental Insurance

Subscriber's Name _____

Subscriber's Employer_____

Subscriber's DOB _____Subscriber's SSN# _____

Relationship to Patient _____

Insurance Carrier _____

Subscriber's Sex:

Insurance ID#_____

Group #_____

Insurance Address _____

_____

Insurance Phone (_____) _____

Health History

Physician's Name _____

Physician's Location _____

Physician's Phone Number _____

Date of last complete physical exam _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes ☐ No ☐

If yes, please list_____

List any medications (including non-prescription) you are currently taking _____

_____

Are you pregnant? If so, how many weeks

Are you wearing removable dental appliances?

When was your last dental exam?_____

Do you have dental implants? _____

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Have you had or do you currently have any of the following?

YES	NO	
☐	☐	AIDS/HIV
☐	☐	Alcoholism
☐	☐	Allergy
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arteriosclerosis
☐	☐	Arthritis, Rheumatism:
☐	☐	Artificial Heart Valves
☐	☐	Artificial Joints
☐	☐	Asthma/Hay Fever
☐	☐	Back Problems
☐	☐	Abnormal Bleeding
☐	☐	Have you ever required a blood transfusion?
		If yes, when? _____
☐	☐	Blood Diseases
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Chest Pain
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions
☐	☐	Cortisone Treatments
☐	☐	Coronary Insufficiency
☐	☐	Coronary Occlusion
☐	☐	Cough, persistent or bloody

YES	NO	
☐	☐	Damaged Heart Valves
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy or other neurological disease
☐	☐	Fainting/Dizziness/Seizures
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Heart Attack
☐	☐	Heart Defects, congenital
☐	☐	Heart Murmurs
☐	☐	Heart Problems:
		If yes, what? _____
☐	☐	Hemophilia
☐	☐	Hepatitis
		If yes, what type? _____
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Immune System Compromised
☐	☐	Jaundice
☐	☐	Jaw Pain
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Menstrual Problems
☐	☐	Mitral Valve Prolapse

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YES	NO		YES	NO	
☐	☐	Nervous Problems	☐	☐	Tumor or growth on head or neck
☐	☐	Pacemaker	☐	☐	Ulcer/Stomach Hyperacidity
☐	☐	Psychiatric Care	☐	☐	Sexually Transmitted Diseases
☐	☐	Radiation Treatment	☐	☐	Weight Loss, unexplained or
☐	☐	Respiratory Disease			persistent diarrhea
☐	☐	Rheumatic Fever			**Pre-medicate prior to dental appointments?**
☐	☐	Rheumatic Heart Disease			**Are you allergic or have you had a reaction to:**
☐	☐	Scarlet Fever	☐	☐	Local anesthetic
☐	☐	Shortness of Breath	☐	☐	Penicillin or other antibiotics
☐	☐	Sinus Trouble	☐	☐	Sulfa Drugs
☐	☐	Skin Rash	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	Special Diet	☐	☐	Aspirin
☐	☐	Stroke	☐	☐	Iodine
☐	☐	Swollen Feet or Ankles	☐	☐	Codeine or other narcotics
☐	☐	Swollen Neck Glands	☐	☐	Latex
☐	☐	Thyroid Problems			
☐	☐	Tobacco Habit			
☐	☐	Tonsillitis			
☐	☐	Tuberculosis			

Other _____

Do you have any disease, condition, or problem not listed?

_____

Are you available short notice? _____

Do you live or work nearby? _____

OUR POLICY

- **I certify that I have read and have answered the questions to the best of my ability. I will not hold Dr. Progebin and/or his staff responsible for any errors or omissions that I have made in the completion of this form.**
- **I acknowledge that a copy of this office's Notice of Privacy Practices is available to me.**
- **I give consent to take dental photographs, send correspondence, and to share them with other dental/medical professionals via email.**
- **I understand that Dr. Progebin will not provide any financial information with other dental/medical professionals via email.**
- **I understand 24 hours notice must be given if I need to cancel or reschedule my appointment, otherwise I will be charged a cancellation fee.**
- **I give consent to perform treatments and services necessary in the course of my treatment.**
- **I understand that I am financially responsible for all charges incurred during my course of treatment.**

Signature of Patient _____ **Date** _____

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