PATIENT INFORMATION

DATE: _____

LEGAL NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTH DATE: ___/___/___ TELEPHONE: _____
MONTH DAY YEAR HOME# WORK# CELL#

E-MAIL: _____

PLACE OF EMPLOYMENT: _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME: _____ GRADE: _____

FAMILY PHYSICIAN'S NAME: _____ PHONE: _____

DENTAL INSURANCE ☐ NO ☐ YES (Complete insurance information)
Has any member of your family ever been treated in our office? ☐ YES ☐ NO

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

FAMILY INFORMATION

HUSBAND (FATHER, if a minor)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

WIFE (MOTHER, if a minor)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone _____

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapetic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the Dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me.

I agree, in order for the Dental Office to service my account, notify me of information pertaining to my account, appointment, dental condition, or for the purpose of collection, you may contact me by telephone at any number I provide to you, including wireless telephone numbers. I may also be contacted via e-mail or text messages using any e-mail address/wireless number I provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device.

Payment in full (or patient portion if you have insurance) is due at the first appointment of each service. As a courtesy, if you have insurance, we will file it for you and allow 30 days for their payment. If you do not pay the entire balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.75% per month (or a minimum charge of $2.00/annual rate of 21%) applied to the last month's balance.

In the case of default of payment, I agree to pay interest on the balance due, together with all cost of collection including attorney fees, collection foes, and contingent fees of collection of not less than 35%. Such contingent fees to be added and collected by the collection agency or attorney immediately upon my default and referral of my account to said collection agency.

X _____

Relationship _____

Date _____

Legal Name _____ Preferred Name _____ Birthdate _____

1. Have you been under the care of a medical doctor during the past 5 years? **yes** **no**
   If yes, for what reason? _____
2. Are you allergic to or made sick by any of the following medications: (Please circle if yes)

Aspirin	Demerol	Erythromycin	Other Anesthetics _____
Acetaminophen (tylenol)	Lortab	Tetracycline	Other medicines _____
Ibuprofen	Valium	Penicillin	Other Antibiotics _____
Darvocet	Sedative	Novacaine/Xylocaine/Mepivacaine	
Codeine	Nitrous Oxide	_____	

3. Are you taking any drug, medicine or pills? **yes** **no**
   If yes, what? _____
4. Have you had treatment for a tumor, growth, or other condition of your head or neck? Surgery? **yes** **no**
   Radiation therapy? **yes** **no**
   Chemotherapy? **yes** **no**
   Other? **yes** **no**
5. Have you ever been told by your physician or dentist that you need to take an antibiotic before surgery or dental procedures? **yes** **no**
   If yes, for what reason? _____
6. Have you ever had any excessive bleeding requiring special treatment? **yes** **no**
7. Are you taking any medication for the treatment of osteoporosis? **yes** **no**
   If yes, what? _____
8. Circle any of the following which you have had or have at present.

***Heart Murmur**	Stroke	Radiation Treatment	Hemophilia
***Rheumatic Fever**	Irregular Heart Beat	Chemotherapy (Cancer, Leukemia)	Venereal Disease (Syphilis, Gonorrhea)
***Artificial Heart Valve**	Kidney Trouble	Cancer/Tumor	Cold Sores
***Mitral Valve Prolapse**	Ulcers	Arthritis	Epilepsy or Seizures
***Heart Surgery**	Anxiety	Rheumatism	Fainting or Dizzy Spells
***Artificial Joint**	Emphysema	taken Cortisone Medicine	Nervousness
***Heart Pacemaker**	Chronic Bronchitis	Glaucoma	Psychiatric Treatment
Heart Failure	Cough	Pain in Jaw Joints	Sickle Cell Disease
Heart Disease or Attack	Tuberculosis (TB)	Hepatitis A (infectious)	Bruise Easily
Angina Pectoris/Chest Pain	Asthma	Hepatitis B (serum)	HIV Positive
High Blood Pressure	Hay Fever	Hepatitis C	AIDS
Low Blood Pressure	Sinus Trouble	Liver Disease	LATEX ALLERGY
Congenital Heart Lesions	Allergies or Hives	Yellow Jaundice	Other Medical Conditions
Scarlet Fever	Diabetes	Blood Transfusion	
Anemia	Thyroid	Drug or Alcohol Abuse	

***If yes to any of the * above please call prior to your appointment. PREMEDICATION MAY BE REQUIRED**

9. Do you have any disease, condition or problem not listed? (9.) **yes** **no**
   If yes, what? _____
10. **WOMEN:** Are you pregnant now? (10.) **yes** **no**
    Are you taking birth control pills? **yes** **no**
    Do you anticipate becoming pregnant? **yes** **no**
11. Do you smoke or use tobacco in any form? (cigarette, cigar, pipe, chew, snuff, smokeless tobacco, etc.) (11.) **yes** **no**

Dental History

12. What is the approximate date of your last examination? _____
    a. Last date your teeth were cleaned? _____
    b. Last date you had dental x-rays? _____ how many _____
    c. Previous Dentist (optional) _____
13. Are you having any dental pain? (13.) **yes** **no**
14. Are your teeth frequently sensitive to hot, cold or sweets? (14.) **yes** **no**
15. Are your gums frequently sore or tender? (15.) **yes** **no**
16. Do your gums bleed when you brush your teeth? (16.) **yes** **no**
17. Do you think your teeth and gums are having a harmful affect on your general health at this time? (17.) **yes** **no**
18. Have you ever had periodontal (gum) surgery? (18.) **yes** **no**
19. Are you satisfied with the appearance of your teeth? (19.) **yes** **no**
20. In general, do dental treatments cause you much concern or worry or make you tense? (20.) **yes** **no**
21. Have you had any unusual difficulties associated with any previous dental treatment? (21.) **yes** **no**
    If yes, explain _____
22. Have you been instructed in home care of your teeth? (22.) **yes** **no**
23. Have you noticed any swelling around any teeth? (23.) **yes** **no**
24. Do you have an unpleasant taste or odor in your mouth? (24.) **yes** **no**
25. Do you often clench or grind your teeth when asleep or angry? (25.) **yes** **no**
26. Do you have popping, clicking, or soreness of jaws? (26.) **yes** **no**

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

_____

Date Signature of Patient, Parent of Guardian

MICHAEL A. PITT, DDS, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgment

I have received, or been given the opportunity to view the office's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

Signature (or Guardian, if minor) Date

___You may disclose information to my family members and/or non-family members.
(Protected Health Information would include your name, diagnosis(es), test results, dates of service.)

Please list name, phone number, and relationship.

Name	Phone Number	Relationship

You may disclose insurance information to a referring dental office.

_____ _____

Patient's signature (or Guardian , if minor) Date

_____ _____

Patient's Printed Name Social Security Number

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited us from obtaining acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other

_____

YOUR DENTAL PROGRAM IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. THIS OFFICE FILES YOUR INSURANCE AS A COURTESY TO YOU. WE WILL BE GLAD TO ASSIST YOU IN OBTAINING THE MAXIMUM BENEFITS SPECIFIED IN YOUR CONTRACT.

We can file your claim **ONLY** when you provide the following:

- ***Plan benefit booklet or printed benefit information.***
- ***Claim form and/or insurance card. (mailing address and phone number)***

PLEASE COMPLETE THE FOLLOWING:

PERSON WITH INSURANCE (PRIMARY)

Name of insured:_____ SS# _____ DOB:_____

Address:_____

Policy # _____ Group # _____

EMPLOYER - Name:_____ Phone #_____

Address:_____

INSURANCE COMPANY - Name:_____ Phone #_____

Address:_____

IF YOU HAVE A SECONDARY DENTAL INSURANCE PLEASE COMPLETE

Name of insured:_____ SS# _____ DOB:_____

Address:_____

Policy # _____ Group # _____

EMPLOYER - Name:_____ Phone #_____

Address:_____

INSURANCE COMPANY - Name:_____ Phone #_____

Address:_____

PLEASE KEEP THIS PORTION FOR YOUR RECORDS

IT IS IMPORTANT YOU REALIZE...

YOU (NOT THE INSURANCE COMPANY) ARE RESPONSIBLE TO US FOR ALL OF YOUR FEES FOR SERVICE RENDERED TO YOU.

Your fee schedule is determined by your employer and their insurance carrier. Our fees generally, but not necessarily, fall within most usual and customary fees..

Not all dental services are a covered benefit in all contracts.

Based on information we receive from the insurance company or employer, an ESTIMATE will be given of the benefits that the insurance company is expected to pay, and any co-pay is expected at the time services are rendered. Only at the time of insurance payment will we know exactly what the actual benefit will be.

It is the patient's responsibility to know if you are covered at the time the service is rendered, deductible amounts, policy renewal dates and the remaining benefits for the year.

If for any reason your insurance company will only pay benefits to you, you will be expected to pay in full at the time of service and the insurance company will reimburse you directly.