

PATIENT INFORMATION

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have questions regarding your health, treatment, appointments, fees, etc., please do not hesitate to ask.

Date _____ Name: First _____ Last _____
Preferred Name _____ Birthdate _____ SSN# _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Email Address _____ Sex: ___M ___F
Spouse Name _____ Spouse Phone# _____
Spouse Birthdate _____ Spouse _____ Email _____
Whom _____ may _____ we _____ thank _____ for _____ referring _____ you?



IN CASE OF EMERGENCY PLEASE CONTACT:

Name _____ Relationship to you _____
Phone Number of Emergency Contact Person _____



Insurance Company _____ Group# _____
Subscriber Name _____ Member ID# _____
Employer Name _____ Occupation _____
Subscriber Birthdate _____ Subscriber SS# _____ Relationship to patient _____
Secondary Insurance? Y or N Insurance Company _____
Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all Information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

Who is responsible for this account? _____ Relationship _____

X
Responsible Party signature _____ Relationship _____ Date _____



DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ Phone# _____
Date of last dental visit _____ Date of last x-rays _____
Please circle Yes or No to indicate if you have had any of the following:

Bad Breath	Y N	Bleeding gums	Y N	Blisters on lips or mouth	Y N
Burning Sensation	Y N	Smoker	Y N	Chewing tobacco	Y N
Dry Mouth	Y N	Fingernail biting	Y N	Popping or clicking jaw	Y N
Jaw joint pain	Y N	Food Collection	Y N	Grinding Teeth	Y N
Mouth breathing	Y N	Lip or cheek biting	Y N	Orthodontic treatment	Y N
Loose teeth	Y N	Swollen gums	Y N	Sensitivity to cold	Y N

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Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather due occur. We ask our patients to give us 24 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who are waiting for treatment.

Policy and Fees:

Cancellation or rescheduling of an appointment with **24 hours or more notification** – no charge

Failure to give 24 hour notice:

-We allow one (1) broken appointment within a 12 month period

-Any additional broken appointment within a 12 month period will be charged a fee of \$85.00 for a normal scheduled appointment for an hour or less, each additional hour incures an additional fee of \$50.00.

Definition of “**Broken Appointment**”: A broken appointment is when you **Cancel or Reschedule** an appointment with less than 24 hour notice or **Do Not Show Up** for the scheduled appointment.

It is extremely important to respond to your appointment reminder notices sent to you by text messaging, e-mail or by a phone call, and show for your confirmed appointment.

Our goal is to keep the cost of dental services as economical as possible. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care. Thank you for understanding and respecting our time policy as we do our best to respect your time in return.

I have read and understand the above mentioned policy.

Patient Signature: _____ Date: _____