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_____
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# _____
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
Sensitivity to hot	Y N	Sensitivity to sweet	Y N	Sensitivity to bite	Y N

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

MEDICAL HISTORY

Primary Physician's Name _____ Date of last visit _____

Please circle Y or N to indicate if you have had any of the following:

AIDS	Y N	Epilepsy	Y N	Psychiatric Care	Y N
Anemia	Y N	Fainting or dizziness	Y N	Radiation Treatment	Y N
Arthritis or Rheumatism	Y N	Glaucoma	Y N	Respiratory Disease	Y N
		Headaches	Y N	Rheumatic Fever	Y N
Artificial heart Valves	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
		Heart Attack or Stroke	Y N	Shortness of breath	Y N
Artificial Joints	Y N			Sinus Trouble	Y N
Asthma	Y N	Hepatitis Type _____	Y N	Swelling of Feet or Ankles	Y N
Bleeding Abnormally	Y N	High Blood Pressure	Y N	Swollen Neck Glands	Y N
Blood disease	Y N	HIV positive	Y N	Thyroid Problems	Y N
Cancer	Y N	Joint Replacement	Y N	Tonsillitis	Y N
Chemical Dependency	Y N	Kidney Disease	Y N	Tuberculosis	Y N
		Liver disease	Y N	Tumor or growth on Head or Neck	Y N
Chemotherapy	Y N	Low Blood Pressure	Y N		
Circulatory Problems	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
		Nervous Problems	Y N	Venereal Disease	Y N
Congenital Heart Lesions	Y N	Pacemaker	Y N	Surgeries:_____	
		Women:		_____	
Cortisone Treatments	Y N	Are you pregnant:	Y N	_____	
		Due Date_____		Other _____	
Diabetes	Y N	Are you nursing	Y N	_____	

Current Medications_____

Allergies:_____

Pharmacy Name: _____ Phone Number: _____

All co-payments are due at the time of service. If we are not participating providers of your insurance plan, and you do not have out-of-network benefits, payment in full is expected at the time of your visit. I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use any photographs for in-office patient education.

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 996 (HIPPA), I have been given the opportunity to review/obtain a copy of, Joseph M. Pitts DMD, PC, Notice of Privacy Practices. I consent to the use and disclosure of my protected Health Information to obtain payment information in connection with my dental claims.

Please be advised that we charge for broken appointments without a 24 hour notification.

_____ _____

Patient's Signature Date

Joseph M. Pitts, D.M.D.

573 Concord Road, Suite B
Smyrna, GA 30082
770-432-3381

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: _____