Pitt Family Dental

Name _____ Date_____
FIRST MI LAST

Address_____City_____State_____ Zip_____

E-mail_____ Cell Phone(____)_____ Home Phone (____)_____

SS#_____ Birth Date____/____/_____ ____ Male ____Female

Circle the appropriate marital status: Minor Single Married Divorced Widowed Separated

If College Student: F.T. P.T. Name of School _____ City_____ State _____

Patient's or Parent's Guardian's Employer _____ Work Phone (____)_____

Business Address _____ City_____ State____ Zip_____

Spouse or Parent's/Guardian's Name_____ Employer _____Work Phone (____)_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____)_____

Responsible Party

Name of person responsible for this account _____ Relation to patient_____

Address _____ Home Phone (____)_____

Birth Date ____/____/_____ SS#_____

Employer_____Work Phone (____)_____

Is this person currently a patient in our office? Yes No

Insurance Information

Name of Insured _____ Relation to patient_____

Birth Date ____/_____/_____ SS# _____ Date Employed ____/____/_____

Name of Employer _____ Union or Local # _____ Work Phone (____)_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co. _____ Phone (_____)_____ Grp # _____ Subscriber I.D #_____

Ins. Co. Address _____City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max annual benefit_____

Do you have any additional insurance? Yes No If **Yes**, Complete the following

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Name of Insured _____ Relation to patient_____

Birth Date ____/_____/_____ SS# -----_____ Date Employed ____/____/_____

Name of Employer _____ Union or Local # _____ Work Phone (____)_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co. _____ Phone (_____)_____ Grp # _____ Subscriber I.D #_____

Ins. Co. Address _____City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max annual benefit_____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____Date of last visit _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

☐ Bad Breath	☐ Periodontal Treatment
☐ Bleeding Gums	☐ Sores/Growths in your mouth
☐ Clicking/Popping Jaw	☐ Sensitivity to Heat
☐ Food Collection between teeth	☐ Sensitivity to Sweets
☐ Grinding teeth	☐ Sensitivity when Biting
☐ Loose Teeth	☐ Sensitivity to Cold
☐ Broken Fillings	☐ Finger-Thumb Sucking

Have you had your wisdom teeth removed? Yes No
Do you have a family history of congenitally missing teeth? Yes No
Are you happy with your smile?_____ If not, what would you change?_____

MEDICAL HISTORY

Have you had any serious illnesses or operations? If yes, please explain_____
Have you ever had a blood transfusion? If yes, give approximate dates_____
Have you ever or do you currently smoke? Yes No || Smoke e-cigarette? Yes No || Use tobacco? Yes No
Women, are you pregnant? Yes No ||Nursing? Yes No ||Taking Birth Control? Yes No

CHECK IF APPLICABLE:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Artificial Limbs
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy/ Radiation
- ☐ Chemical Dependency
- ☐ Congenital Heart Defect
- ☐ Cosmetic surgery
- ☐ CPAP/Sleep Apnea
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches/ Migraines
- ☐ Glaucoma
- ☐ HIV or AIDS
- ☐ Hay Fever
- ☐ Heart Attack or Stroke
- ☐ Heart Murmur or Arrhythmia
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pain in Jaw Joints
- ☐ Pneumocystitis
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Taken Fen-Phen
- ☐ Tonsils/Adenoid Removed
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers

ALLERGIES: CIRCLE IF APPLICABLE

Aspirin Latex
Codeine Metals
Dental Anesthetic Penicillin
Erythromycin Tetracycline
Jewelry

Other:_____
_____
_____

PLEASE LIST ALL MEDICATIONS AND ANY MEDICAL CONDITIONS NOT LISTED.

PITT FAMILY DENTAL

Office Policy Agreement

It is customary that payment is due on the day that services are rendered. You will be given an estimate of the costs. Please ask if you have any questions.

Insured Patients

We will be happy to process your insurance forms for your insurance carrier. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases.

Insurance Benefits

Benefits depend solely on what the purchaser (employer) wishes to offer. Some plans cover as little as 30% or as much as 100% of covered services with most falling in the 50% to 80% range. **It is your responsibility to know what is covered by your insurance. We cannot stress enough that insurance is not, and has never been, a guideline for quality care.**

Co-payment

You agree to pay all charges/balances/unpaid claims. Please understand that dental insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible.

Account Balance

The balance of the account is due in full within 90 days of services rendered regardless of any previously paid co-payment and / or outstanding insurance claims. A finance charge of 1.5% per month (18% annually) will be assessed for accounts over 90 days. **We suggest you contact your insurance company if payment has not been made within 45 days from the date of service.**

Collections Fees and Costs

Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Print Name_____

Signature_____Date_____