Dear Patient,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

To facilitate being seen quickly at the time of your appointment, please complete the new patient information forms **before** your arrival and **please be 15 minutes early** for your appointment. Please bring the completed forms and your dental insurance card with you at the time of your appointment or you may mail them back to us prior to your appointment. We will gladly file your insurance for you, **we do ask that your co-payment and/or deductible be paid at time of services and any remaining balance be paid within 45 days of assigned claims.**

When being seen for dental visits, please refrain from wearing any scented lotions, perfume, or cologne for the comfort of those around you with allergies.

If you are unable to keep your appointment you have scheduled with us, please allow at least a **48 hour business days notice (Monday – Thursday) for all appointment changes**. We will be glad to reschedule the appointment at a more convenient time if necessary. In the meantime, we look forward to meeting you and serving your dental health needs.

Thanks again for choosing our dental practice!

Sincerely,

Dr. Brad Pitts and Staff

117 Old Chapin Road • Lexington, SC 29072 • (803) 808-1778 • Fax (803) 808-1821 • Email bradpittsdmd@sc.rr.com

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Brad Pitts, DMD

Medical History for Office of Dr. Brad Pitts

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	
Have you had any abnormal Bleeding	Yes No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Other Antibiotics

Question	Answer	If yes
Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No
Stomach Ulcers	Yes No	Pacemaker	Yes No				

Question	Answer	If yes
Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________

PATIENT'S DENTAL HISTORY

PATIENT'S NAME ______________________________ DATE OF BIRTH ______________

REASON FOR THIS VISIT ______________________________

WHEN WAS YOUR LAST DENTAL VISIT ______________ WHAT WAS DONE THEN ______________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN ______________________________

PREVIOUS DENTIST (NAME AND LOCATION) ______________________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE ______________

HOW OFTEN DO YOU BRUSH YOUR TEETH ______________ HOW OFTEN DO YOU FLOSS YOUR TEETH ______________

IS YOUR DRINKING WATER FLUORIDATED ______________________________

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT ______________		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________________________

____

____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X ______________________________ DATE ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS ______________________________

____

______________ SIGNATURE ______________________________ DATE ______________

Form 219114 N/04/11 Item 40684 Brad Pitts, D.M.D. Patterson Office Supplies 800.637.1140

PATIENT'S NUMBER

HEALTH HISTORY

Brad Pitts, DMD, LLC

We now participate in an online system that sends emails and texts. These features include:

-Appointment Reminders *-Confirm Appointments via Email*
-Request Appointments Online *-Refer your friends online*
-Submit Patient Satisfaction Surveys

To participate please provide the following:

Email Address:__________________________________

Cell#____________________________

Office Policies

Dr. Brad Pitts, DMD, LLC

So that we may provide you with outstanding customer service and care, please review the following policies:

Initial **Office Hours**: Monday through Thursday from 8:30am until 5:00pm (Closed for Lunch 1-2pm)

_____ **Payment is due when services are rendered.** We accept cash, checks, Visa, MasterCard, American Express and Discover. Additional financing is available pending approval through Care Credit.

_____ **Insurance:** We accept assignment of most dental plans. However, we do require payment of the **estimated** co-payment portion of your bill at the time of service. After your dental plan processes your claim, you will be responsible for any remaining balance. Your policy is a contract between you and the insurance company. We are not a party to that contract. If your dental plan has not paid your account in full within 45 days, the balance must be paid once you receive your statement. Please be aware that some, and perhaps all of the services provided may be non covered services and may not be considered reasonable and customary under your dental plan. Our practice is committed to providing excellent patient care and our charges are usual and customary for our area. You are responsible for payment regardless of a dental plan's arbitrary determination of usual and customary rates. Please be advised that if your treatment is not covered under your specific plan, full payment is due at the time of service.

_____ **Adult/Minor Patients:** Adult patients are responsible for full payment of their estimated portion of fees at the time of service. The adult/parent/guardian accompanying a minor is responsible for payment at the time of service as well. Children under the age of 16 MUST be accompanied by a parent or guardian at all times. For unaccompanied minors, non emergency treatment will be denied unless charges have been prearranged.

_____ **Guarantee of Work:** Dr. Pitts guarantees restorative work for five years depending upon your maintaining individual home care needs. This is also contingent upon you keeping your recommended treatment and preventive care appointments. The non compliance of the above will make this guarantee null and void.

_____ **Missed Appointments:** We certainly understand that scheduling conflicts do occur. In order to prevent assessing a broken appointment fee of $50.00, **we require 2 business days notice for cancellations.** For appointments on Monday, please call by Wednesday for appointment changes as our office is closed on Fridays. This time is reserved exclusively for you and is not shared with others. Please help us help you by keeping your reserved time. We now require a **$100 deposit to appoint for any treatment over $500.** This deposit is to reserve your appointment and will be applied to your total cost when treatment is completed. You will not lose this deposit if you need to cancel as long as you give 2 business days notification. Only cancellations with less than 2 business days notification will forfeit your deposit.

_____ **Billing Statements:** Statements are mailed once a month. We will also send you a statement when a payment is received from your dental plan to inform you of your remaining balance. Payment in full is expected on all statements, unless prior financial arrangements have been made.

_____ **Interest:** We reserve the right to charge interest in the amount of 1 ½% (18% APR) as provided by state law.

_____ **Returned Checks:** There is a $25.00 charge for checks that are returned due to insufficient funds and payment will be immediately due in cash.

_____ **Collection Fees:** For delinquent accounts that are sent to a collection agency, you agree to reimburse us the fees of that collection agency based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees that we incur in such collection efforts.

I have read and understand the above office policies and agree to all terms stated above.

X____ Date ____________________

Signature of Patient or Responsible Party

Guarantee of Work

Brad Pitts, DMD, LLC

Dr. Brad Pitts guarantees restorative work for up to 5 years depending upon the patient maintaining individual home care needs. This guarantee of work is contingent upon the patient keeping their recommended treatment and preventative care appointments. The non-compliance of the above will make this guarantee null and void.

(Print) Patient Name: ___________________________________

(Sign) Patient/ Guardian: _________________________________

Date: ____

To whom may we thank for your referral to our office.

(Please check all that apply)

- [ ] Person (name) ____________________________
- [ ] Internet Search/Website
- [ ] Doctor Referral (name) ____________________________
- [ ] Radio Ad
- [ ] Lexington Life Magazine Ad
- [ ] Yellow Pages Ad
- [ ] Other Ad ________________________________
- [ ] Sign Out Front
- [ ] Other Source _____________________________

HIPPA PRIVACY NOTICE-PATIENT ACKNOWLEDGEMENT

I have received, read, and agreed to the Notice of Privacy Practices given by Brad Pitts, DMD regarding protection of Personal Health Information.

Patient Name: ______________________________ **Date:** ____________

Patient/Guardian Signature: ______________________________

HIPPA Release of Dental Information

I, ________________________ give Brad Pitts DMD, the authorization to disclose protected personal health/dental information about my appointments/care/records with the following individual(s) listed below:

Name: ______________________________________

Relationship: ________________________________

Name: ______________________________________

Relationship: ________________________________

This release will remain in effect until terminated by myself in written consent.

Patient/Guardian Signature: ______________________ **Date:** _________

~ Dr. Brad Pitts: 117 Old Chapin Road, Lexington, SC 29072 ~ Telephone 803-808-1778

803-808-1778 Office
803-808-1821 Fax
brpittsdmd@yahoo.com

Authorization for Release of Dental Records and X-rays

Date: ____________________

I, hereby authorize the doctors and staff of ________________________________ to release records or knowledge concerning my dental heath to:

Dr. Brad Pitts
Family and Cosmetic Dentistry
117 Old Chapin Rd.
Lexington, SC 29072

I specifically request that you release copies of all x-rays and all treatment notes.

(Print) Patient's Name: ______________________________________

(Signed) Patient Name or Guardian: ________________________________