

Family & Cosmetic Dentistry

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, <u>please complete the new</u> <u>patient information forms before your arrival</u> and <u>please be 15 minutes early</u> 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, <u>we do ask that your co-</u><u>payment and/or deductible be paid at time of services and any remaining balance be</u><u>paid within 45 days of assigned claims</u>.

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

PATIENT REGISTRATION

ID:	Chart ID:				
First Name:		Last Name:			Middle Initial:
Patient Is: Policy	Holder Responsible Party	Preferred Name:			
Responsible Party	y (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	s Lie:
Responsible Party is	s also a Policy Holder for Patient	Primary Insurance Policy H	folder		econdary Insurance Policy Holder
Patient Information	on ————				
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	
E-mail:			ike to receive corr		
	Section 2			•	- Section 3
Employment	Full Time Part Time	Retired			
Status:					
Student Status: H	Full Time Part Time	·• ·			
	Pref. Den Pref. Pharma				
Employer ID:	Pref. Pharma				
Carrier ID:	Pref. H	iyg:	I		
Primary Insurance	Information				
Name of Insured:		Relati	ionship to Insured	l: 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 Insura	nce Information				
Name of Insured:		Relat	ionship to Insured	l: 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

Real Property of the

Ahbugh dental personnel primark treat the area is and around your mouth. your mouth is a part of your entire body. Health problems that you may medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the follows Are you under a physician's care now? Yes No If yes they you taken, Prime-Fen of Reduz? Yes No If yes bo you take, or have you taken, Prime-Fen of Reduz? Yes No If yes yes No If yes we you had any abnormal Bleeding we you had any abnormal Bleeding we you all adars the following? Yes No If yes yes No If yes we you all adars the following? Normer: Are you: Again Normer: Are you: Again Norme Are you had, any of the following? Again Norme Are you had, any of the following? Again Norme Are you: Again Norme Are you had, any of the following? Again Norme Are you: Again Norme Are you: Again Norme Are you: Again Norme Are you: Area wou had, any of the following? Area body of the second and and the personne Norme Are you: Area body of the second and and the personne Norme Are you: Area body of the following? Area body of the second and the personne Norme Are you: Area body of the Norme Are you had, any of the following? Area body of the following? Norme Are you had, any of the following? Norme Are you had any abnorme Norme Are you had any abnorme Norme Are you: Norme Are you had any abnorme Nor	ceptives?
Have you ever been hospitalized or had a major Yes No II yes persition? Have you ever taken bis head or neck injury? Yes No II yes Do you take, or have you taken, Phen-Fen or Redux? Do you take, or have you taken, Phen-Fen or Redux? Yes No II yes Do you taken, or have you taken, Phen-Fen or Redux? Yes No II yes Have you ever taken Fosamax, Boniva, Actonel or my other medications containing bisphosphonetes? Yes No II yes Do you use tobacco? Yes No II yes Do you use tobacco? Yes No II yes Do you as controlled substances? Yes No II yes Do you use controlled substances? Yes No Cortisone Medicine Yes No Diabetes Yes No Early didition Yes No Apprina Yes No Early didition Yes No Andprinks Yes No Egalepsy or Saturces Yes No Andprinka Yes No Frequent Hindra Yes No Biod Disease Yes No Frequent Hindra Yes No Biod Disease Yes No Frequent Hindra Yes No Biod Disease Yes No Frequent Houdrehes Yes No Biod Disease Yes No Frequent Headeches Yes No Biod Disease Yes No Ho Frequent Hindra Yes No Biod Disease Yes No Ho Frequent Headeches Yes No Biod Disease Yes No Ho Frequent Headeches Yes No Contisoner Yes No Heart Marrow Yes No Biod Disease Yes No Heart Marrow Yes No Contereal Disease Yes No Heart Marta/Failure Yes No Cond Soreylever Bisters Yes No Hear	c
peration? dave you ever had a serious head or neck injury? Yes No If yes be you take, or have you taken, Phen-Fen or Redux? Yes No If yes be you take, or have you taken, Phen-Fen or Redux? Yes No If yes be you take, or have you taken, Phen-Fen or Redux? Yes No If yes the you on a special diet? Yes No If yes the you on a special diet? Yes No If yes or you use tabacco? the you and any abnormal Bleeding Yes No If yes or you allerge to any of the following? Apprint Nursing? Taking oral contraceptives? e you allerge to any of the following? Apprint Nether Activity Internet States or you use controlled substances? Yes No If yes or you have, or have you had, any of the following? Alb/HIT Positive X Anemia Yes No Easily Winded Yes No Anemia Yes No Easily Winded Yes No Anemia Yes No Easily Winded Yes No Anemia Yes No Easily Winded Yes No Anthrtis/Gout Yes No Easily Winded Yes No Athrtis/Gout Yes No Easily Winded Yes No Biodo Tanestice Yes No Biodo Tanesti	c
ave you ever had a serious head or neck injury? Yes No If yes ver you taking any medications, pills, or drugs? Yes No If yes ver you haking any medications, pills, or drugs? Yes No If yes ver you as pacial diet? Yes No If yes ver you as special diet? Yes No If yes ver you as special diet? Yes No If yes ver you had any abnormal Bleeding Yes No If yes ver you had any abnormal Bleeding Yes No If yes ver you alargic to any of the following? Yes No If yes Ves No If yes No	c
re you taking any medications, pills, or drugs? Yes No II yes to you take, or have you taken, Phen-Fen or Redu? Yes No II yes tave you ever taken Fosamax, Bonka, Actonel or yes No II yes re you a special diet? Yes No II yes re you as special diet? Yes No II yes re you as tabacco? Yes No II yes re you and any abnormal Bleeding Yes No II yes re you aller the following? Acrylic Acryl	c
av you take, or have you taken, Phen-Fen or Redux? Yes No If yes	c
ave you ever taken Fosamax, Boniva, Actonel or ny otter medications containing bisphosphonates? re you on a special diet? o you use totacco? ave you had any abnarmal Bleeding o you use totacco? ave you alergic to any of the following? Aprin Pregnant/Trying to get pregnant? Nursing? Aprin Penicillin Metal other Antibiotics o you use controlled substances? Ty es No If yes o you use controlled substances? Ty es No If yes Out use controlled substances? Ty es No If yes Out use controlled substances? Ty es No It yes Out use controlled substances? Ty es No It yes Out use controlled substances? Ty es No It yes Ty es No Naphyloxis Ty es No Naphyloxis Ty es No It yes No Naphyloxis State Disease Ty es No It yes No Naphyloxis State Disease Ty es No It yes No State Disease Ty es No It yes No Naphyloxis State Disease Ty es No It yes No State Disease Ty es No It yes No Naphyloxis State Disease Ty es No It yes No It we yes No It	c
ny other medications containing bisphosphonates? re you on a special diet? Yes No you use tobacco? Yes No you use tobacco? Yes No re you alergic to any of the following? Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? you alergic to any of the following? Agrin Prenicillin Prenicillin Metal Latex Sulfa Drugs Local Anesthetics ther Antibiotics o you use controlled substances? Yes No If yes No I	c
o you use tobacco? ave you had any abnormal Bleeding Yes No Cortisone Medicine Yes No Hepatitis & or C Yes No Recart Weight Loss Recart Recar	c
ave you had any abnormal Bleeding Yes If yes mmen: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? ryou allergic to any of the following? Penicillin Codeine Acrylic ayes controlled substances? Yes No If yes Acrylic op uu se controlled substances? Yes No If yes If yes you have, or have you had, any of the following? Cortisone Medicine Yes Yes No Diabetes Yes Yes No Herophilia Yes No Anemina Yes No Easily Winded Yes No Herophilia Yes No Nanaphylaxis Yes No Easily Winded Yes No Heropatitis & or C Yes No Andentifical Heart Valve Yes No Excessive Bleeding Yes No Heropatitis & or C No Scalet Fever High Cholesterol Yes No Excessive Thirts Yes No Scalet Fever High Cholesterol Yes No Epilepsy or Seizures Yes	c
amen: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? e you alergic to any of the following? Apprin Penicillin Codeine Acrylic Aspirin Penicillin Codeine Sulfa Drugs Local Anesthetics Other Antibiotics Ves No If yes Local Anesthetics other Antibiotics Cortisone Medicine Yes No If yes you have, or have you had, any of the following? Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Achehemer's Disease Yes No Drug Addiction Yes No Hemophilia Yes No Radiation Treatments Angina Yes No Easily Viinded Yes No Hepatitis B or C Yes No Renal Dialysis Arthficial Joint Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Asthma Yes No Frequent Headaches Yes No Highes No Singles Stroke No Frequent Diarrhos Yes No Higheses Yes No Stroke No Frequent Headaches Yes No Higheses Yes	c
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? a you alergic to any of the following? Apprin Penicillin Acrylic Aspirin Penicillin Sulfa Drugs Acrylic Other Antibiotics Sulfa Drugs Latex Sulfa Drugs Local Anesthetics Other Antibiotics Yes No If yes If yes If yes If yes If yes Recent Weight Loss Recent Weight Loss AlbS/HIV Positive Yes No If yes Yes No Hemophilla Yes No Recent Weight Loss Anaphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Recent Weight Loss Angina Yes No Easily Winded Yes No Herps Yes No Recent Weight Loss Arthritis/Gout Yes No Easily Winded Yes No Herps Yes No Rheumatism Staffa Drugs Yes No Faiting Spelly/Dizzness Yes No Heysenria Yes No Kolewnia Yes No Arthritis/Gout Yes No Faiting Spelly/Dizzness Yes No Heysenria Yes No Kolewnia Yes No Sinde Cell Disease	c
a spirin Penicillin Codeine A crylic Aspirin Penicillin Latex Sulfa Drugs Local Anesthetics Other Antibiotics Sulfa Drugs Local Anesthetics Local Anesthetics Other Antibiotics Yes No If yes Local Anesthetics you have, or have you had, any of the following? If yes Hemophilia Yes No Anaphylaxis Yes No Diabetes Yes No Anemia Yes No Easily Winded Yes No Arthritis/Gout Yes No Easily Winded Yes No Frittical Joint Yes No Easily Winded Yes No Frequent Cough Yes No Frequent Cough Yes No Storde Yes No Frequent Cough Ye	c
Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Other Antibiotics Yes No If yes Local Anesthetics you use controlled substances? Yes No If yes Local Anesthetics you have, or have you had, any of the following? Cortisone Medicine Yes No Hemophilia Yes No Naphrijabis Yes No Diabetes Yes No Hepatitis A Yes No Angina Yes No Easily Winded Yes No Hepatitis B or C Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Scarlet Fever Staddod Disease Yes No Excessive Thirst Yes No Scale Cell Disease Straing Spelk/Dizzines Yes No Frequent Cough Yes No Scarlet Fever Straing Spelk/Dizzines Yes <t< td=""><td></td></t<>	
Metal Latex Sulfa Drugs Local Anesthetics Other Antibiotics o you use controlled substances? Yes No If yes ther? If yes If yes If yes you have, or have you had, any of the following? Cortisone Medicine Yes No Naphylaxis Yes No Drugs Addiction Yes No Anemia Yes No Drug Addiction Yes No Herpatis SA Yes No Naphylaxis Yes No Drug Addiction Yes No Herpatis SA Yes No Naphylaxis Yes No Drug Addiction Yes No Herpatis SA Yes No Andmina Yes No Emphysema Yes No Herpatis SA Yes No Nathritis/Cout Yes No Excessive Bleeding Yes No Herpatis A Yes No Not christe Easily Yes No Frequent HeadAches Yes No Sick Cell Disease Sick Cell Disease Sick Cell Disease Sick Oe S	
Other Antibiotics o you use controlled substances? Yes No If yes uther? If yes you had, any of the following? XIDS/HV Positive Yes No Naphylaxis Yes No Pressor Yes No Drug Addiction Yes No Angmia Yes No Pressor Pressor Angmia Yes No Easily Winded Yes No Excessive Bleeding Yes No Artificial Heart Vale Yes No Frequent Diartes Yes No Statma Yes No Statma Yes No Statma Yes No Frequent Diartel Yes No Statma Yes No Statma Yes No Gaucoma Yes No Frequent Diarthea Yes No Stoked Disease Yes No Stoked Statma Yes No Stoked Transfusion Yes No Gaucoma Yes No Cheer Heart Murmur Yes No Cheer Heart Nurmur Yes No Cheart	Anesthetics
by you use controlled substances? ther? Yes No JDS/HIV Positive Yes No JDD detes Yes No Lizheimer's Disease Yes No Herpes Yes No Herpes Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Pololetrol Yes No Frequent Cough Frequent Dough Yes No JCC Yes No High Blood Pressure Yes No High Pololetrol Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Heart Murmur Yes No Parathyroid Disease Yes No Heart Murmur Yes No Parathyroid Disease Yes No Heart Murmur Yes No Parathyroid Disease Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Yes No Parathyroid Disease Yes No Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Ye	
ther? If yes you have, or have you had, any of the following? Dis/HIV Positive Yes No Hemophilia Yes No Radiation Treatments Izbeimer's Disease Yes No Drug Addiction Yes No Hemophilia Yes No Recent Weight Loss naphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Read Treatments namina Yes No Easily Winded Yes No Hepatitis B or C Yes No Read Iblalysis rthritis/Gout Yes No Easily Winded Yes No High Blood Pressure Yes No Reaumatic Fever rthficial loaint Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever sthma Yes No Frequent Cough Yes No Frequent Headaches Yes No Sinus Trouble lood Transfusion Yes No Galucoma Yes No Lewer Disease Yes No Swelling of Limbs theart Attack/Failure Yes No Heart Attack/Failure Yes No No No attow Noe No hold Sores/Fever Blisters Yes No Heart Attack/Failure Yes	
ther? If yes you have, or have you had, any of the following? Dis/HIV Positive Yes No Hemophilia Yes No Radiation Treatments Izbeimer's Disease Yes No Drug Addiction Yes No Hemophilia Yes No Recent Weight Loss naphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Read Treatments namina Yes No Easily Winded Yes No Hepatitis B or C Yes No Read Iblalysis rthritis/Gout Yes No Easily Winded Yes No High Blood Pressure Yes No Reaumatic Fever rthficial loaint Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever sthma Yes No Frequent Cough Yes No Frequent Headaches Yes No Sinus Trouble lood Transfusion Yes No Galucoma Yes No Lewer Disease Yes No Swelling of Limbs theart Attack/Failure Yes No Heart Attack/Failure Yes No No No attow Noe No hold Sores/Fever Blisters Yes No Heart Attack/Failure Yes	
LIDS/HIV PositiveYesNoCortisone MedicineYesNoHermophiliaYesNoRadiation TreatmentsNzheimer's DiseaseYesNoDrug AddictionYesNoHepatitis AYesNoRecent Weight LossNamiaYesNoDrug AddictionYesNoHepatitis B or CYesNoRecent Weight LossNamiaYesNoEasily WindedYesNoHepatitis B or CYesNoRecent Weight LossNaginaYesNoEasily WindedYesNoHepatitis B or CYesNoRecent Weight LossAuginaYesNoEasily WindedYesNoHepatitis B or CYesNoRecent Weight LossAutificial Heart ValveYesNoExcessive BleedingYesNoHigh CholesterolYesNoScarlet FeverAutificial JointYesNoFrequent CoughYesNoHreguesYesNoSinus TroubleAlood DiseaseYesNoFrequent CoughYesNoLeukemiaYesNoSiomach/Intestinal DiseaseAutor EasilyYesNoGenital HerpesYesNoLue DiseaseYesNoStrokeChest PainsYesNoGaucomaYesNoHird Valve ProlapseYesNoTumors or GrowthsChest PainsYesNoHaart Attack/FailureYesNoHird Valve ProlapseYesNoTumors or Growt	
AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hermophilia Yes No Radiation Treatments Alzeheimer's Disease Yes No Drug Addiction Yes No Hermophilia Yes No Recent Weight Loss Anaphylaxis Yes No Drug Addiction Yes No Herpatitis B or C Yes No Angina Yes No Easily Winded Yes No Herpatitis B or C Yes No Arthritis/Gout Yes No Epileps or Seizures Yes No Herpatitis B or C Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No High Blood Pressure Yes No Arthritis/Gout Yes No Frequent Cough Yes No Scarlet Fever Athma Yes No Frequent Cough Yes No Frequent Cough Yes No Blood Disease Yes No Frequent Headaches Yes No Storake Storake Storake	
Atzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Anaphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Recent Weight Loss Anemia Yes No Easily Winded Yes No Hepatitis A Yes No Reumatic Fever Angina Yes No Emphysema Yes No High Blood Pressure Yes No Scarle Fever Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Scikle Cell Disease Attificial Joint Yes No Excessive Thirst Yes No Hives or Rash Yes No Scikle Cell Disease Athod Disease Yes No Frequent Cough Yes No Leukemia Yes No Spina Bifida Mod Disease Yes No Genital Herpes Yes No Low Blood Pressure Yes No Spina Bifida Mod Disease <t< td=""><td>n Treatments 💿 Yes 🕥</td></t<>	n Treatments 💿 Yes 🕥
AnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRenal DialysisAnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverAnginaYesNoEmphysemaYesNoHerpesYesNoRheumatic FeverArtificial Heart ValveYesNoEpilepsy or SeizuresYesNoHigh CholesterolYesNoScarlet FeverArtificial JointYesNoExcessive BleedingYesNoHives or RashYesNoSickle Cell DiseaseArtificial JointYesNoExcessive ThirstYesNoHypoglycemiaYesNoSickle Cell DiseaseBlood DiseaseYesNoFrequent CoughYesNoFrequent PoblemsYesNoSimus TroubleBlood TransfusionYesNoGenital HerpesYesNoLuverniaYesNoSwelling of LimbsTruise EasilyYesNoGaucomaYesNoLung DiseaseYesNoSwelling of LimbsChernotherapyYesNoHaart Attack/FailureYesNoAttack/FailureYesNoStokeTorsillitisChernotherapyYesNoHeart Attack/FailureYesNoAttack/FailureYesNoAttack/FailureYesNoChernotherapyYesNoHaart Attack/FailureYesNoAttack/FailureYes	Weight Loss 💿 Yes 💿
Ameria Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Angina Yes No Emphysema Yes No High Blood Pressure Yes No Scarlet Fever Authritis/Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Scarlet Fever Authriticial Joint Yes No Excessive Bleeding Yes No Hives or Rash Yes No Singles Nothring Spells/Dizzness Yes No Fainting Spells/Dizzness Yes No Frequent Cough Yes No Sinus Trouble Sinus Trouble Jood Disease Yes No Frequent Cough Yes No Frequent Headaches Yes No Sinus Trouble Sinus Trouble Joacora Yes No Genital Herpes Yes No Luver Disease Yes No Swelling of Limbs Anneer Yes No Genital Herpes Yes No Heart Attack/Failure Yes No Swelling	
wrthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh CholesterolYesNoScarlet FeverAuthritis/GoutYesNoExcessive BleedingYesNoHigh CholesterolYesNoSickle Cell DiseaseAushmaYesNoFainting Spells/DizzinessYesNoHigh CholesterolYesNoSickle Cell DiseaseAushmaYesNoFainting Spells/DizzinessYesNoHigh CholesterolYesNoSickle Cell DiseaseAushmaYesNoFrequent CoughYesNoFrequent DiarrheaYesNoSinus TroubleAlood TransfusionYesNoFrequent HeadachesYesNoLeukemiaYesNoAreathing ProblemsYesNoGenital HerpesYesNoLuxer DiseaseYesNoCancerYesNoGlaucomaYesNoLung DiseaseYesNoThyroid DiseaseChest PainsYesNoHeart Attack/FailureYesNoPain in Jaw JointsYesNoTuberculosisConvulsionsYesNoHeart Trouble/DiseaseYesNoParethyroid DiseaseYesNoYellow Jaundiceave you ever had any serious illness not listedYesNoIf yesYesNoYellow Jaundice	atic Fever 💿 Yes 💿
Arthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh CholesterolYesNoScarlet FeverArtificial Heart ValveYesNoExcessive BleedingYesNoHigh CholesterolYesNoShinglesArtificial JointYesNoExcessive ThirstYesNoHigh CholesterolYesNoSickle Cell DiseaseArtificial JointYesNoFainting Spells/DizzinessYesNoHigh CholesterolYesNoSickle Cell DiseaseArtificial JointYesNoFrequent CoughYesNoFrequent DiarrheaYesNoSinus TroubleBroadtring ProblemsYesNoFrequent HeadachesYesNoLeukemiaYesNoSinus TroubleBruise EasilyYesNoGaucomaYesNoLow Blood PressureYesNoSwelling of LimbsChemotherapyYesNoHay FeverYesNoMitral Valve ProlapseYesNoThyroid DiseaseConversionsYesNoHeart MurmurYesNoPain in Jaw JointsYesNoTumors or GrowthsConvulsionsYesNoHeart Trouble/DiseaseYesNoPacemakerYesNoYellow JaundiceAve you ever had any serious illness not listedYesNoIf yesYesNoYellow Jaundice	atism 💿 Yes 💿
wrtificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles wrtificial Joint Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles wrtificial Joint Yes No Fainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Cough Yes No Sickle Cell Disease Sinus Trouble lood Transfusion Yes No Frequent Cough Yes No Leukemia Yes No Spina Bifida reathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Spina Bifida ancer Yes No Genital Herpes Yes No Liver Disease Yes No Swelling of Limbs chemotherapy Yes No Glaucoma Yes No Hiral Valve Prolapse Yes No Thyroid Disease Tonsillitis cheart Attack/Failure Yes No Heart Murmur Yes No	Fever 🔘 Yes 🔘
AsthmaYesNoFainting Spells/DizzinessYesNoI'rregular HeartbeatYesNoSinus Troublelood DiseaseYesNoFrequent CoughYesNoI'rregular HeartbeatYesNoSpina Bifidalood TransfusionYesNoFrequent DiarrheaYesNoI'rregular HeartbeatYesNoSimach/Intestinal Diseasereathing ProblemsYesNoFrequent HeadachesYesNoI'rregular HeartbeatYesNoStomach/Intestinal Diseaseruise EasilyYesNoGenital HerpesYesNoIow Blood PressureYesNoSwelling of LimbsCancerYesNoGlaucomaYesNoIung DiseaseYesNoThyroid DiseaseChemotherapyYesNoHay FeverYesNoNoHeart Attack/FailureYesNoTuberculosisCold Sores/Fever BlistersYesNoHeart MurmurYesNoPain in Jaw JointsYesNoHuors or GrowthsConvulsionsYesNoHeart Trouble/DiseaseYesNoYesNoYesNoYellow Jaundiceave you ever had any serious illness not listedYesNoIf yesIf yesIf yesIntestinal DiseaseYesNo	s 📀 Yes 💿
sthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble lood Disease Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Sinus Trouble Spina Bifida reathing Problems Yes No Frequent Headaches Yes No Stomach/Intestinal Disease ancer Yes No Genital Herpes Yes No Glaucoma Yes No hemotherapy Yes No Glaucoma Yes No Heart Attack/Failure Yes No Tuberculosis old Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No onvulsions Yes No Heart Trouble/Disease Yes No Pacemaker Yes No ave you ever had any serious illness not listed Yes No If yes If yes If yes	
Nood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Nood Disease Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Stomady/Intestinal Disease reathing Problems Yes No Frequent Headaches Yes No Leukemia Yes No Stomady/Intestinal Disease ruise Easily Yes No Genital Herpes Yes No Genital Herpes Yes No Swelling of Limbs ruise Easily Yes No Gaucoma Yes No Mitral Valve Prolapse Yes No Swelling of Limbs ruise Easily Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Thyroid Disease heart Attack/Failure Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Tumors or Growths onvulsions Yes No Heart Trouble/Disease Yes No Yes No Yellow Jaundice	rouble 💿 Yes 💿
lood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomadu/Intestinal Disease reathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stomadu/Intestinal Disease ruise Easily Yes No Genital Herpes Yes No Genital Herpes Yes No Swelling of Limbs cancer Yes No Glaucoma Yes No Hay Fever Yes No Hung Disease Yes No Thyroid Disease chest Pains Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Tuberculosis old Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths onvulsions Yes No Heart Trouble/Disease Yes No Yes No Yellow Jaundice ave you ever had any serious illness not listed Yes No If yes If yes If yes If yes </td <td>ifida 💿 Yes 💿</td>	ifida 💿 Yes 💿
reathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke ruise Easily Yes No Genital Herpes Yes No Liver Disease Yes No Swelling of Limbs cancer Yes No Glaucoma Yes No Hay Fever Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Huert Attack/Failure	
ruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Thyroid Disease chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Thyroid Disease old Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Tuberculosis ongenital Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Attack/Failure Yes No Hurrors or Growths ulcers Yes No Heart Trouble/Disease Yes No Yes No Yellow Jaundice we you ever had any serious illness not listed Yes No If yes If yes If yes	🔘 Yes 🔘
Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Chest Pains Yes No Cold Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Disorder Yes No Convulsions Yes No Attack Yes No Pacemaker Yes No If yes	a of Limbs 🛛 🔘 Yes 🔘
hemotherapy Yes No hest Pains Yes No old Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Obsores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Yes No Parathyroid Disease Yes No Venereal Disease Yes No Yellow Jaundice ave you ever had any serious illness not listed Yes No If yes	
hest Pains Yes No old Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Yes No Heart Trouble/Disease Yes No Yes No Heart Trouble/Disease Yes No Yes No we you ever had any serious illness not listed Yes No If yes	
old Sores/Fever Bisters Yes No ongenital Heart Disorder Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Venereal Disease Yes No Ave you ever had any serious illness not listed Yes No	
ongenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Convulsions Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Yellow Jaundice Stomach Ulcers Yes No Yes No Yes No If yes ave you ever had any serious illness not listed Yes No If yes If yes If yes	
Convulsions Ores No Heart Trouble/Disease Ores No Venereal Disease Ores	🔘 Yes 🌍
ave you ever had any serious illness not listed Ores No If yes	
nments:	

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.

Date:_____

Signature of Patient, Parent or Guardian:

Х

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-RA	AYS) TAKEN WHEN/WHERE
HOW OFTEN DO YOU BRUSH YOUR TEETH	HOW OFTEN DO YOU FLOSS YOUR TEETH
IS YOUR DRINKING WATER FLUORIDATED	

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

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.

х

HEALTH HISTORY

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

Brad Pitts, DMD, LLC

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

-Appointment Reminders -Request Appointments Online -Submit Patient Satisfaction Surveys

To participate please provide the following:

Email Address:_____

Cell#_____

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

Office Policies Dr. Brad Pitts, DMD, LLC

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 delinguent 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.

Initial

Date

X______ 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 <u>all</u> that apply)

Person (name)
Internet Search/Website
Doctor Referral (name)
Radio Ad
Lexington Life Magazine Ad
Vellow Pages Ad
Other Ad
Sign Out Front
Other Source



hamily & Cosmetik Dentistry

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

Brad Pitts

Family & Cosmetic Dentistry

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

Authorization for Release of Dental Records and X-rays

Date: _____

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: