**PITT FAMILY DENTAL**
CENTERVILLE, UTAH

801.295.6192 · MONDAY–THURSDAY 7 A.M.–5 P.M.
WWW.PITTFAMILYDENTAL.COM

TODAY'S DATE

## PATIENT INFORMATION

NAME | SOCIAL SECURITY NUMBER

BIRTH DATE | HOME PHONE | MOBILE PHONE

ADDRESS | CITY+STATE | ZIP

PLEASE CHECK THE APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF STUDENT, NAME OF SCHOOL/COLLEGE | CITY | STATE

PATIENT'S OF PARENT'S EMPLOYER | WORK PHONE

BUSINESS ADDRESS | CITY+STATE | ZIP

SPOUSE OR PARENT'S NAME | EMPLOYER | WORK PHONE

PERSON TO CONTACT IN CASE OF EMERGENCY | PHONE

WHOM MAY WE THANK FOR REFERRING YOU? | RELATIONSHIP TO PATIENT

## RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT | RELATIONSHIP TO PATIENT

ADDRESS | HOME PHONE

DRIVER'S LICENSE | BIRTH DATE

EMPLOYER | WORK PHONE

CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

## INSURANCE INFORMATION

NAME OF INSURED | RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER | BIRTH DATE | DATE EMPLOYED

EMPLOYER | WORK PHONE

EMPLOYER ADDRESS | CITY+STATE | ZIP

INSURANCE COMPANY | GROUP NUMBER | UNION OR LOCAL NUMBER

ADDRESS | CITY+STATE | ZIP

HOW MUCH IS YOUR DEDUCTIBLE? | HOW MUCH HAVE YOU USED | MAXIMUM ANNUAL BENEFIT

## ADDITIONAL INSURANCE

NAME OF INSURED | RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER | BIRTH DATE | DATE EMPLOYED

EMPLOYER | WORK PHONE

EMPLOYER ADDRESS | CITY+STATE | ZIP

INSURANCE COMPANY | GROUP NUMBER | UNION OR LOCAL NUMBER

ADDRESS | CITY+STATE | ZIP

HOW MUCH IS YOUR DEDUCTIBLE? | HOW MUCH HAVE YOU USED | MAXIMUM ANNUAL BENEFIT

## DENTAL HISTORY

REASON FOR TODAY'S VISIT | DATE OF LAST DENTAL VISIT

FORMER DENTIST | DATE OF LAST DENTAL X-RAYS

ADDRESS | CITY+STATE | ZIP

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ CLICKING OR POPPING JAW
- ☐ FOOD COLLECTION BETWEEN THE TEETH
- ☐ GRINDING TEETH
- ☐ LOOSE TEETH OR BROKEN FILLINGS
- ☐ PERIODONTAL TREATMENT
- ☐ SORES OR GROWTHS IN YOUR MOUTH
- ☐ SENSITIVITY TO HEAT
- ☐ SENSITIVITY TO SWEETS
- ☐ SENSITIVITY WHEN BITING
- ☐ SENSITIVITY TO COLD

HOW OFTEN DO YOU FLOSS? | HOW OFTEN DO YOU BRUSH?

## MEDICAL HISTORY

PHYSICIAN'S NAME | DATE OF LAST VISIT

☐ YES ☐ NO HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN?" THESE INCLUDE COMBINATION OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE).

☐ YES ☐ NO HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? IF YES, PLEASE DESCRIBE ____________

☐ YES ☐ NO HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF YES, GIVE APPROXIMATE DATES ____________

☐ YES ☐ NO WOMEN, ARE YOU PREGNANT? | ☐ YES ☐ NO NURSING? | ☐ YES ☐ NO TAKING BIRTH CONTROL PILLS?

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

- ☐ ANEMIA
- ☐ ARTHRITIS, RHEUMATISM
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CHEMOTHERAPY
- ☐ CIRCULATORY PROBLEMS
- ☐ CORTISONE TREATMENTS
- ☐ COUGH, PERSISTENT
- ☐ COUGH UP BLOOD
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEADACHES
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HEMOPHILIA
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV / AIDS
- ☐ JAW PAIN
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MITRAL VALVE PROLAPSE
- ☐ PACEMAKER
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SKIN RASH
- ☐ STROKE
- ☐ SWELLING OF FEET OR ANKLES
- ☐ THYROID PROBLEMS
- ☐ TOBACCO HABIT
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ ULCER
- ☐ VENEREAL DISEASE

## MEDICATIONS

DO YOU REQUIRE ANTIBIOTICS BEFORE A DENTAL VISIT? IF YES, PLEASE LIST ____________

LIST MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS ____________

ALLERGIES ____________

## OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN. INITIALS ________ DATE ________

DOCTOR'S COMMENTS ____________

## MEDICAL HISTORY UPDATE

I HAVE READ MY MEDICAL HISTORY AND CONFIRMED THAT IT STATES PAST AND PRESENT MEDICAL CONDITIONS.

HISTORY UPDATE DATED | SIGNATURE | DATE

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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 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

IN THE EVENT ANY BALANCE IS NOT PAID AS AGREED, THE UNDERSIGNED AGREES TO PAY A COLLECTION FEE NOT TO EXCEED 40% OF THE UNPAID BALANCE. IN THE EVENT OF A LAWSUIT TO COLLECT THE UNPAID BALANCE, THE UNDERSIGNED AGREES TO PAY COURT COSTS AND REASONABLE ATTORNEY'S FEES IN ADDITION TO THE COLLECTION FEE. YOU AUTHORIZE US TO CALL YOU AT ANY NUMBER YOU PROVIDE OR AT ANY NUMBER WHICH WE REASONABLY BELIEVE WE CAN CONTACT YOU, INCLUDING CALLS TO MOBILE, CELLULAR, OR SIMILAR DEVICES FOR ANY LAWFUL PURPOSE. YOU AGREE TO ANY AN FEE(S) OR CHARGE(S) THAT YOU MAY INCUR FOR INCOMING CALLS FROM US, AND/OR OUTGOING CALLS TO US, TO OR FROM ANY SUCH NUMBER, WITHOUT REIMBURSEMENT FROM US.

**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