

PATIENT INFORMATION

DATE _____

Name _____
Last First Middle Nickname
Address _____ Apt # _____
City _____ State _____ Zip code _____
Home Phone() _____ Work Phone() _____ Ext _____
Cell Phone() _____ Pager() _____

☐ Married ☐ Single ☐ Child ☐ Other
Birthday / /
Driver's License # _____ State _____
Social Security # _____
E-mail _____

Employer _____
Occupation _____
Business Address _____
City _____ State _____ Zip code _____

In case of an emergency, please contact:
Name _____ Relationship _____
Phone _____ Cell phone _____
Nearest relative not living with you _____
Relationship to patient _____ Phone _____

Whom may we thank for referring you? _____
Is another member of your family a patient at our office? ☐ Yes ☐ No Their name? _____

Method of payment: ☐ Cash ☐ Check ☐ VISA/MC/Discover

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT ☐ Patient ☐ Parent ☐ Guardian

Name _____
Last First Middle Nickname
Address _____ Apt # _____
City _____ State _____ Zip code _____
Home Phone () _____ Work Phone() _____ Ext _____
Cell phone/pager _____ E-mail _____
How long at present address? _____

Social Security # _____
Driver's License # _____ State _____
Birthday / /
Employer _____
Occupation _____
Business Address _____
City _____ State _____ Zip _____

DENTAL HISTORY

1. Are you presently in pain? ☐ YES ☐ NO
☐ Teeth ☐ Jaw ☐ Gums ☐ Face ☐ Other
2. Have you had any teeth removed? ☐ YES ☐ NO
If the teeth were replaced, how? _____
3. Is any part of your mouth sensitive to the following? ☐ YES ☐ NO
☐ Hot ☐ Cold ☐ Pressure ☐ Sweet ☐ Sour ☐ Other
4. Have you ever had periodontal treatment or gum surgery? ☐ YES ☐ NO
If YES, when? _____ By whom? _____
5. Please check known conditions:
☐ Bleeding gums when brushing ☐ A burning sensation in your mouth ☐ Grind/clench at night
☐ Food catches between your teeth ☐ Bad taste or odor in your mouth ☐ Jaw clicking or popping
☐ Feel anxious about dental treatment ☐ Unusual dryness in your mouth ☐ Tired, stiff, or painful jaw muscles
6. Are you aware of any growths or swellings in your mouth? ☐ YES ☐ NO
If YES, where are they located and how long have they existed? _____
7. Are you dissatisfied with the appearance of your teeth? ☐ YES ☐ NO
If YES, what would you most like to change? _____
8. Are you interested in learning how to control dental disease to preserve your teeth & oral health? ☐ YES ☐ NO
9. Have you had any unpleasant dental experiences? Do you have concerns we need to be aware of? ☐ YES ☐ NO
If yes, explain: _____

HEALTH HISTORY

Please complete the following confidential information. Your complete answers will assist us in treating you with consideration for your special needs.

Family Physician _____ Date of last visit _____ Reason for this visit _____

1. Do you have a current medical problem or condition? Condition: _____ ☐ YES ☐ NO
If yes, physician's name: _____ Phone: _____

2. Have you been hospitalized or have you had a serious illness within the last 5 years? ☐ YES ☐ NO
If so, list illness or operations/dates: _____

3. Do you have heart trouble or any form of cardiovascular disease (Please (✓) check known conditions)? ☐ YES ☐ NO

- | | | |
|--|---|--|
| ☐ Heart surgery (Date _____) | ☐ Angina/chest pains (Frequency _____) | ☐ High blood pressure |
| ☐ Prosthetic heart valve (Date _____) | ☐ Heart attack (Date _____) | ☐ Stroke (Date _____) |
| ☐ Bypass (Date _____) | ☐ Heart murmur | ☐ Low blood pressure |
| ☐ Angioplasty (Date _____) | ☐ Mitral valve defect | ☐ Atherosclerosis |
| ☐ Pacemaker (Date _____) | ☐ Congenital heart defect | ☐ Other _____ |

4. Please list any medications and dosages you currently take or have taken in the last year: _____

5. Are you under any unusual stress at home or at work? If yes, explain: _____

6. Do you or have you ever had any of the following (please (✓) check all known conditions)? ☐ YES ☐ NO

- | | | |
|--|--|---|
| ☐ Tuberculosis (Date _____) | ☐ Epilepsy or seizures | ☐ Hepatitis (Date _____ Type _____) |
| ☐ Liver disease or jaundice | ☐ Persistent cough | ☐ Fainting or dizzy spells |
| ☐ Kidney disease | ☐ Emphysema/Asthma | ☐ Arthritis |
| ☐ Diabetes (Type I or II) | ☐ Sinus trouble/Hay fever | ☐ Chronic head, neck or back pain |
| ☐ Hypo/Hyperglycemia | ☐ Allergies or hives _____ | ☐ Artificial joint, limb, or implant (hip, knee) |
| ☐ Glaucoma | ☐ HIV | ☐ Nervousness |
| ☐ Hypo/Hyperthyroidism | ☐ AIDS or ARC | ☐ Psychiatric treatment |
| ☐ Stomach or intestinal ulcers | ☐ Herpes | ☐ Alcoholism |
| ☐ Prolonged bleeding | ☐ Drug Addiction | ☐ Venereal Disease (Syphilis, Gonorrhea) |
| ☐ Anemia | ☐ Cancer _____ | ☐ Special diet |
| ☐ Sickle cell disease | ☐ Chemotherapy (Date _____) | ☐ Cosmetic Surgery (face, neck) |
| ☐ Blood transfusion | ☐ Cortisone medicine | ☐ Wearing contact lenses |
| ☐ Bruise easily | ☐ Limitation of activity | ☐ Other _____ |
| ☐ Smoking history- (cigarettes, e-cigarettes, smokeless tobacco (dipping), hooka,, vaping & recreational drugs.
age: _____ Packs/day: _____ other usage: _____ | | |

7. Have you ever taken prophylactic antibiotics prior to dental treatment? ☐ YES ☐ NO

8. Are you allergic to or have you had any unusual reaction to any drugs or medicines? ☐ YES ☐ NO
If yes, please list: _____

9. Are you allergic to or have you ever reacted adversely to latex? ☐ YES ☐ NO

10. Have you had surgery, radiation or other treatments for a tumor or growth to head or neck? ☐ YES ☐ NO

11. For women only: Are you pregnant? If so what month? _____ ☐ YES ☐ NO
Are you taking birth control pills? ☐ YES ☐ NO

I understand the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of service. The above medical information is correct to the best of my knowledge. If I have any change in my health or medications, I will inform the doctor at my next appointment. I hereby authorize the release of any medical information to an insurance company I claim benefits with and assign those benefits to Thomas H. Pitts, D.M.D. In addition, I hereby grant permission for the release of any medical information to any physician, if deemed necessary for my dental care. I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation, and give consent for dental treatment to be performed by Dr. Pitts and his staff. I understand the use of anesthetic agents embodies a certain risk. I consent to receive phone calls or text messages regarding my treatment with Dr. Pitts.

Patient Signature _____ Date _____
Parent/Financially Responsible Person _____ Relationship _____

Thomas H. Pitts, D.M.D.
138 Leisure Lane
Columbia, SC 29210
803♦750♦5494

YOUR VISIT WITH US

I am pleased that you have chosen me to provide your dental care. I want to assure you that you will receive the personal and professional attention you deserve. I will strive to bring you the best procedures and practices that are available in contemporary dentistry. At the same time, my staff and facility will provide a relaxed, nurturing, and clinically safe environment for your treatment.

In order to achieve this style of **Personal Care**, I have limited my practice to a smaller patient base. This allows me to develop a strong doctor-patient relationship. You will receive exceptional care in a small private practice, where discussing your needs with the doctor is the norm, rather than the exception.

As a new patient, you will receive a comprehensive, preventative-oriented examination and a personalized treatment plan to enable you to restore and maintain superb oral health. This is followed regularly with periodic checkups and an updated comprehensive examination every four years.

In order to facilitate your treatment, I ask that you please arrive a few minutes early for each appointment. Your reserved appointment time is dedicated solely to you based on the treatment recommended. Consequently, you will seldom have to wait because we do not overbook appointments. Our individually dedicated scheduling process is a time saving feature for your benefit that makes this practice unique and special for our patients, but it also makes missed appointments catastrophic for us. For this reason, it is imperative that you **DO NOT** miss an appointment. Please make sure that the appointment you schedule is one you will be able to keep. If you are unable to keep a scheduled appointment, we ask that you call us at least 48 hours in advance. This courtesy on your part allows us to use the time for another patient in need.

Because of the specialized treatment we provide, we cannot tolerate any missed appointments or any appointments canceled at the last minute. *If this occurs, a service charge per appointment and/or a setup fee for treatment may apply. Total fees may constitute up to 1/2 the cost of treatment to be provided based on the procedure.* Consecutively failed appointments may result in a terminated patient/doctor relationship.

I am aware of the many options available to you when seeking a dentist for your needs, and I consider it a privilege that you have chosen me to care for your dental health. Thank you for your confidence, and I look forward to serving you and your family. I especially welcome referrals of your family and friends who are seeking the **Personal Care** style of dental treatment I provide.

Patient Signature _____ Date _____

Thomas H. Pitts, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Donna

Telephone: (803) 750-5494 Fax: (803) 750-1444

E-mail: mysmiledoc@bellsouth.net

Address: 138 Leisure Lane, Columbia, SC 29210

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____