ELIZABETH S. PITTMAN D.M.D.

REGISTRATION FORM

(Please Print-all field must be answered)

Today's date:						

PATIENT INFORMATION

Patient's Name:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Are you the patient? ❑ Yes ❑ No	If not, what is your name?	Relationship to Patient:	Patient Birth Date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security #:	Best # to reach you: ( )			
City:	State/ Zip Code:	Email Address:				
Occupation/Student:	Employer:	Work Phone #: ( )				
Referred to us by (please check one box):	❑ Family ❑ Friend	❑ Insurance Directory	❑ Insurance Website			
❑ Employee	❑ Co-Worker	❑ Walk In	❑ Yellow Pages	❑ Other		
Name of person who referred you:						

FINANCIAL RESPONIBILITY/INSURANCE INFORMATION

(Please give your insurance card/cards and drivers license to the receptionist.)

Person financially liable for charges: (If covered by insurance skip to **A)**	Birth Date: / /	Address :	Phone #: ( )		
❑ Parent ❑ Spouse ❑ Other	Is this person you? ❑ Yes ❑ No	Is this person a patient here? ❑ Yes ❑ No			
Social Security #:	Employer:	Employer address:	Employer Phone #: ( )		
A. Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Delta Dental	❑ Guardian	❑ MetLife	❑ Aetna	❑ GEHA
❑ Humana Dental	❑ United Concordia	❑ Anthem	❑ Other		❑ Discounted Plan
Subscriber's name:	S.S. #:	Birth date: / /	Group #:	ID #:	Effective Date: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Social Security #:	Birth date: / /		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship :	Phone #: ( )	Alternate #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize the dentist or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date* _____

Patient Name: _____ Date: _____

Reason for today's visit: _____

Do you currently have or had any of the following?

❑ Yes	❑ NO	Orthodontic Treatment (Braces/Retainer)	❑ Yes	❑ NO	Taken antibiotic before dental appts
❑ Yes	❑ NO	Oral Surgery	❑ Yes	❑ NO	Clicking/Popping of Jaw
❑ Yes	❑ NO	3rd molars removed (Wisdom Teeth)	❑ Yes	❑ NO	Bleeding/ Swollen Gums
❑ Yes	❑ NO	Deep cleaning	❑ Yes	❑ NO	Jaw Pain
❑ Yes	❑ NO	Gum Treatment	❑ Yes	❑ NO	Floss
❑ Yes	❑ NO	Root Canal Therapy	❑ Yes	❑ NO	Mouth Rinse
❑ Yes	❑ NO	Dentures	❑ Yes	❑ NO	Clench/Grind
❑ Yes	❑ NO	Partials	❑ Yes	❑ NO	Canker Sores
❑ Yes	❑ NO	Oral Piercing	❑ Yes	❑ NO	Cold Sores
❑ Yes	❑ NO	Teeth Whitening	❑ Yes	❑ NO	Dental Implants
❑ Yes	❑ NO	Night Guard	❑ Yes	❑ NO	Loose Teeth
❑ Yes	❑ NO	Manual Toothbrush	❑ Yes	❑ NO	Sensitivity to Hot
❑ Yes	❑ NO	Power Toothbrush	❑ Yes	❑ NO	Sensitivity to Cold
❑ Yes	❑ NO	Water Pik	❑ Yes	❑ NO	Latex Allergy
❑ Yes	❑ NO	Veneers	❑ Yes	❑ NO	Broken/ Dislocated Jaw
❑ Yes	❑ NO	Bad Breath	❑ Yes	❑ NO	Missing teeth

Name of previous Dentist: _____ Date of last visit: _____

Are you happy with the appearance of your teeth ❑ Yes ❑ NO If no, what would you like to change? _____

_____

Have you ever had a bad experience/ problem associated with dental treatment ❑ Yes ❑ NO If yes, please explain____

_____

_____

The information given here regarding the patient medical and dental histories is accurate and complete to the best of my knowledge. I will not hold the dentist or her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any changes occur, it is my responsibility to inform the dentist and her staff.

Patient/Guardian Signature: _____ Date: _____

Office Use

I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: _____ Date: _____ Initials: _____ Date: _____

Patient Name: _____ Date: _____

The information given here is accurate and complete to the best of my knowledge.

Are you allergic to?

❑ Latex ❑ Dental Anesthetics ❑ Penicillin ❑ Erythromycin ❑ Aspirin ❑ Codeine ❑ Sulfa ❑ Metals

❑ Other: _____

Do you use tobacco products? ❑ Yes ❑ NO ❑ Cigarettes ❑ Pipes ❑ Chew ❑ Dip ❑ Daily ❑ Seldom

Consume alcohol beverages? ❑ Yes ❑ NO ❑ Daily ❑ Seldom ☐ Occasionaly

WOMEN Are you or do you think you might be pregnant? ❑ Yes ❑ NO Are you nursing? ❑ Yes ❑ NO

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you currently have or had any of the following? List Medication or drugs taken for the condition.

❑ Yes	❑ NO	Heart Disease	Medication	_____	Notes _____
❑ Yes	❑ NO	Heart Attack	Medication	_____	Notes _____
❑ Yes	❑ NO	Chest Pains	Medication	_____	Notes _____
❑ Yes	❑ NO	Stroke	Medication	_____	Notes _____
❑ Yes	❑ NO	Rheumatic Fever	Medication	_____	Notes _____
❑ Yes	❑ NO	Mitral Valve Prolapse	Medication	_____	Notes _____
❑ Yes	❑ NO	Congenital Heart Disease	Medication	_____	Notes _____
❑ Yes	❑ NO	Artificial Heart Valves	Placed when	_____	Notes _____
❑ Yes	❑ NO	Heart Pacemaker	Placed When	_____	Notes _____
❑ Yes	❑ NO	High Blood Pressure	Medication	_____	Notes _____
❑ Yes	❑ NO	Blood Transfusion	When	_____	Notes _____
❑ Yes	❑ NO	Epilepsy or Seizures	Medication	_____	Notes _____
❑ Yes	❑ NO	Drug Addiction/Alcoholism	Medication	_____	Notes _____
❑ Yes	❑ NO	Implants	Type	_____	Notes _____
❑ Yes	❑ NO	Kidney Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Thyroid Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Liver Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Mental Health Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Bleeding Problems or Hemophilia			
❑ Yes	❑ NO	Genetic Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Hormonal Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Lung Problems	Medication	_____	Notes _____
❑ Yes	❑ NO	Venereal Disease	Medication	_____	Notes _____
❑ Yes	❑ NO	A.I.D.S. / H.I.V. Positive	Medication	_____	Notes _____
❑ Yes	❑ NO	Cortisone/Steroids	Medication	_____	Notes _____
❑ Yes	❑ NO	Persistent Cough	Medication	_____	Notes _____
❑ Yes	❑ NO	Artificial Joints	Type	_____	Notes _____
❑ Yes	❑ NO	Asthma	Medication	_____	Notes _____
❑ Yes	❑ NO	Cancer	Type	_____	Notes _____
❑ Yes	❑ NO	Sinus Trouble	Medication	_____	Notes _____
❑ Yes	❑ NO	Allergies	Medication	_____	Notes _____
❑ Yes	❑ NO	Arthritis	Medication	_____	Notes _____
❑ Yes	❑ NO	Hepatitis	Medication	_____	Notes _____
❑ Yes	❑ NO	Diabetes ❑ Yes Type II	Medication	_____	Notes _____
❑ Yes	❑ NO	Tuberculosis	Medication	_____	Notes _____

List any medications/vitamins/supplements not listed above: _____

_____

Name of Your Physician: _____ Phone # _____

Are you currently under the care of a physician? ❑ Yes ❑ NO What reason? _____

Have you been hospitalized with in the past 12 months? ❑ Yes ❑ NO If yes, for what reason?

_____

Understanding Your Insurance

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary, are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.
Many insurance plans have a yearly maximum amount that they will pay. Be advised that if you reach that maximum, your out-of- pocket cost for procedures may increase.
We do our best to estimate your co-pay amounts prior to dental procedures but it is not a guarantee of your benefits and fees are subject to change. You will be responsible for any remaining amount after insurance is applied.

We hope this information has been helpful. Please take the time to review your insurance contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Sincerely,
Dr. Elizabeth S. Pittman

I, _____ have reviewed and understand the
(PRINT Patient Name)
above information regarding my insurance policy and take full responsibility for any co-pay amounts due for services received that are not paid by my insurance plan.

Signature: _____ Date: _____
(Patient Signature or Guardian if Minor)

Dr. Elizabeth S. Pittman, D.M.D.
FINANCIAL POLICY AGREEMENT

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies.

Patients with Insurance
If you have insurance, we will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

Patients with no Insurance
Full payment is expected on the day of service.

Treatment Plans
Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Composite Restorations
We provide composite (tooth colored) restorations. Your insurance carrier may only pay for amalgam (silver) restorations, therefore you are responsible for the amount not covered by your insurance carrier and this amount is due at the time of service.

Broken Appointments
We reserve the right to charge $50.00 for appointments cancelled or broken without 24 hours notice. This charge must be paid before another appointment can be scheduled. Arriving 10 minutes or more after your scheduled appointment could result in rescheduling your appointment and a broken appointment charge.

Returned Checks
Returned checks will be subject to a $30.00 service fee and charges for any bank fees. This must be paid along with the amount of the check within 10 days or will be turned over to the Fayette County Attorney's Office for collection.

Statement of Services
Statement of Services is due upon receipt. We consider an account delinquent after 30 days, and may be assessed a $5.00 per month service charge. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, $100.00 administrative fee, etc.

Payment Plan Option
We accept Care Credit.

Assignment and Release of Information
I assign the benefits from my insurance carrier to Elizabeth S. Pittman D.M.D. for the dental benefits I am entitled for any services furnished to me. I authorize Elizabeth S. Pittman D.M.D. to release to my insurance carrier any information needed to determine benefits for my care.

Authorization
I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

Please print the name of the patient: _____

Signature of patient (or legal guardian): _____

Date: _____

CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voice mail, text, email or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages- **Messages may include:** Appointment Reminders/Changes, Account Payments/Balances, Cost Estimates, and Needed Treatment/Completed Treatment

O I give my permission for voice and or text messages From Pittman Family Dentistry to be left on my phone number(s) below:

O ell # _____ O ome # _____

O ork# _____

O prefer **not** to have voice mail or text messages from the office

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. Elizabeth Pittman and her representatives at Pittman Family Dentistry to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my appointments, my care or relevant for payment. Ye O o O

NAME RELATIONSHIP PHONE NUMBER

1. _____ _____ _____
2. _____ _____ _____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Printed Patient Name: _____

Signature of patient or guardian (if under 18): _____ Date:_____

Elizabeth S. Pittman, D.M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgement

I, _____, have received/read a copy of this office's
(Paitent Name)

Notice of Privacy Practices. (Posted on our website and in office lobby)

Signature: _____
(Guardian, If Minor)

Date of Signature:_____

OFFICE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgment

__ An emergency situation prevented us from obtaining the acknowledgement

__ Other (please specify) _____