Thomas A. Pittaway D.M.D.

DATE_____

PATIENT INFORMATION

NAME_____DOB_____/_____/_____SS#_____
I prefer to be called_____ Male_____ Female _____
HOME ADDRESS_____CITY_____
STATE_____ZIP_____ HOME PHONE_____CELL PHONE_____
WORK PHONE_____EMAIL ADDRESS_____
PATIENT'S EMPLOYER_____
(If patient is a student please list parent's employer: Father_____ Mother_____)
EMPLOYERS ADDRESS_____
Occupation_____

Whom may we thank for referring you to our practice?_____
Please list any other family members seen by us:_____
In the event of an emergency who should we contact?
Name_____ Relationship to patient_____
Home Phone_____ Work Phone _____

SPOUSE INFORMATION (If applicable)

HIS/HER NAME_____DOB_____/_____/_____ SS#_____
EMPLOYER_____ Occupation_____
WORK PHONE _____EMERGENCY PHONE_____

BILLING INFORMATION

(Complete this section only if the billing information is different from patient information.)

PERSON RESPONSIBLE FOR ACCOUNT_____
DOB_____/_____/_____ SS#_____ Relationship to the patient_____
BILLING ADDRESS_____
HOME PHONE_____ WORK PHONE_____
EMPLOYER_____Occupation_____
EMPLOYER'S ADDRESS_____

DENTAL INSURANCE (Complete this section only if you are covered by dental insurance.)

PRIMARY DENTAL INSURANCE

Insurance Company_____ Insurance Phone_____
Insurance Address_____
Insured's Name_____ Insured's Employer_____
Group # (Plan, Local or Policy #)_____Relationship to patient_____
Insured's DOB_____/_____/_____Insured's SS#_____
Insured's Address_____

SECONDARY DENTAL INSURANCE

Insurance Company_____ Insurance Phone_____
Insurance Address_____
Insured's Name_____ Insured's Employer _____
Group # (Plan, Local or Policy #) _____Relationship to patient_____
Insured's DOB_____/_____/_____ Insured's SS# _____
Insured's Address_____

Please initial each of the following:

_____**Permission for Treatment-** I hereby grant permission to Dr. Pittaway and his team to employ such established treatments and therapy as may be deemed professionally necessary or advisable.

_____**The information I have given today is true to the best of my knowledge.** It is my responsibility to inform this office of any changes in my medical or dental status.

_____**Financial Agreement-** All charges for services and treatment will be paid upon completion of appointment. Outstanding balances shall accrue interest monthly. If I am requesting financing, I authorize this office to obtain my credit history.

_____**If insurance is involved-** I understand that I am solely responsible for the full cost of treatment and services regardless of insurance benefits.

_____**Broken Appointments-** I understand that appointments changed without 24 hours notice may by assessed a broken appointment charge of 50/hour.

_____ _____

Patient, Guardian or Guarantor's Signature Date

We take pride in the care we give our patients, and this becomes possible when we know more about you. Because everyone has different wants and needs we would appreciate it if you would answer the following questions so that we will be prepared to best serve you.

What is most Important to you about your teeth and your smile? _____

_____

What is the most important thing we can do for you at your first visit?_____

_____

What is most important to you about the DENTAL CARE we give you? _____

_____

If we find something that needs to be done in your mouth, do you want all of the details about it, or do you want an overview? _____

_____

DRS. NOTES:_____

_____

_____

_____

_____

_____

_____

_____

Thomas A. Pittaway D.M.D.