Smiles Made Easy

Patient Information

Date______________________

Name____
Last First MI

Phone (_____)______________________ Alt. Phone (_____)______________________ Sex ☐M ☐F

Address__________________________________ E-mail__________________________________

City__________________________________ State______________ ZIP______________

Date of Birth______________________ Age__________ SS/HIC/Patient ID#______________________

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced

Patient Employer/School__________________________________ Occupation______________________

Employer/School Address__________________________________ Empl/School Phone (_____)______________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ______________________________ Phone (_____)______________

Primary Insurance

Person Responsible for Account ____
Last First MI

Relation to Patient ______________________ Date of Birth______________ Soc. Sec.#______________

Address (if different from patient)__________________________________ Phone (_____)______________

City__________________________________ State______________ ZIP______________

Responsible Person Employed by__________________________________ Occupation______________

Business Address __________________________________ Phone (_____)______________

Insurance Company______________________ Group #______________________ Member ID______________

Claims Mailing Address____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________ Date of Birth ______________________ Relationship ______________

Address (if different from patient)__________________________________ Phone (_____)______________

City__________________________________ State______________ ZIP______________

Subscriber Employed by__________________________________ Phone (_____)______________

Insurance Company______________________ Group #______________________ Member ID______________

Claims Mailing Address____

C. THOMAS FITTS III, DMD, FAGD, PA | 4415 Hard Scrabble Road Columbia, SC 29229

Dental Information

Reason for Today's Visit ______________________ Date of Last Dental Care ______________

Former Dentist ______________________ Date of Last Dental X-Rays ______________

Address ____

Check (✓) if you have had problems with any of the following:

☐Bad breath	☐Grinding teeth	☐Sensitivity to hot	☐Bleeding Gums
☐Loose teeth or broken fillings	☐Sensitivity to sweets	☐Bleeding Gums	☐Loose teeth or broken fillings
☐Sensitivity to sweets	☐Clicking or popping jaw	☐Periodontal treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Sensitivity to cold	☐Sores or growths in your mouth	

How often do you floss? ______________ How often do you brush? ______________

Assignment of Insurance Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign
Name of Insurance Company(ies)

directly to Dr. C. Thomas Fitts, III, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________ ______________
Please print name of Patient, Parent Guardian or Personal Representative — Date

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I authorize C. Thomas Fitts, III, DMD, P.A., to contact me regarding treatment, appointments, financials, insurance, and other communication as indicated below in the checked boxes. I authorize contact from office via:

☐U.S. Mail ☐Email ☐Phone and/or Text

I authorize this office to disclose and discuss the patient's protected health information to carry out treatment, payment activities, and health care operations with the following individuals:

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this consent, I authorize C. Thomas Fitts, III, DMD, P.A. to use and disclose my protected health information carry out treatment, payment activities, and health care operations. You may obtain a copy of our notice from out office staff or through our website: www.fittsdental.com.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

______________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

C. Thomas Fitts, D.M.D., P.A.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	If yes
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

- [ ] Pregnant/Trying to get pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Other? [ ] If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X

Date:_________

C. THOMAS FITTS, III, D.M.D., F.A.G.D., P.A.

Consent for Treatment

Please review the following consent and sign it prior to treatment, however, it does not commit you to the treatment. If you have any questions or if there is anything you do not understand, please ask the doctor.

This is my consent for the general dental procedure(s) indicated and any other procedure deemed necessary or advisable as a corollary to the planned therapy performed by the dentist(s) employed by C. Thomas Fitts, III, DMD, F.A.G.D., PA and any assistants with whom they work. I agree to the use of local anesthesia depending upon the judgment of the dentist. I understand the dentist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of general dental procedures and anesthesia may include swelling, bruising, pain, trismus (restricted jaw opening), bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which is rarely protracted and even more rarely is it permanent. I understand that it is my responsibility to report any symptoms to the dentist immediately.

I hereby give Dr. C. Thomas Fitts, III my consent for dental treatment.

____ Date:_______

Patient's Name (PRINT)

____ Date:_______

Signature of Patient, Parent, Guardian or Personal Representative

Appointments

In order to allow the best possible care for our patients we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a 24 hour notice is required. This gives us the opportunity to schedule another patient for treatment. If you do not confirm your appointment at least 24 hours prior to your appointment time your appointment may be given to another patient. A fee of $75.00 per appointment hour will incur without a 24 hour notice. Also, if you are 15 minutes late to your scheduled appointment, the office reserves the right to cancel/reschedule your appointment and a $75.00 fee will be applied.

I have read and understand the above mentioned information. I further understand that I am financially responsible for all charges.

____ _______________

Patient Signature/Parent/Guardian/Personal Representative Date

Revised 6/30/2020

COVID-19 General Dental Treatment Informed Consent

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as the "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, or staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes __________ No __________

Patient/Parent signature______________________________________ Date ____________

Patient's name ____