Phillip T. Fletcher, DDS

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Welcome to our Practice

Chart#:

FOR OFFICE USE ONLY

Patient Name:

Last First MI

Preferred Name

Title:

Mr/Ms/Mrs/etc

Gender: ○ Male ○ Female

Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date:

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone:

Home Mobile Work Ext

Fax Other

Address:

Address 1

Address 2

City State Zip Code _____-____

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name:

Last First MI

Preferred Name

Title: Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

SS#: ___-__-____

DL#:

Email Address:

Best time to call:

Phone:

Home Mobile Work Ext

Fax Other

Address:

Address 1

Address 2

City State Zip Code _____-____

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________________

Phone: ______________

Employer Address:

____
Address 1

____
Address 2

____
City

________ _____-____
State Zip Code

Insurance

Primary Dental Insurance:

Name of Insured:

____
Last

______________________________ ____
First MI

Insured's Birth Date: ______________

ID #: ______________ **Group #:** ______________

Insured's Address:

____
Address 1

____
Address 2

____
City

________ _____-____
State Zip Code

Insured's Employer Name:

____

Employer Address:

____
Address 1

____
Address 2

____
City

________ _____-____
State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

____

Insurance Address:

____
Address 1

____
Address 2

____
City

________ _____-____
State Zip Code

Insurance Company Phone Number:

____

____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured:

Last

First

MI

Insured's Birth Date:

ID #:

Group #:

Insured's Address:

Address 1

Address 2

City

-

State

Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

-

State

Zip Code

Patient's relationship to insured:

◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

-

State

Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Allergies
- ☐ Allergy Azithromycin
- ☐ Allergy, Codeine
- ☐ Allergy, Food
- ☐ Allergy, Ibuprofen
- ☐ Allergy, Latex
- ☐ Allergy, Penicillin
- ☐ Allergy, Sulfa
- ☐ Allergy,Amoxicillin
- ☐ Allergy,Erythromycin
- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ ArtificialHeartValve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ ColdSores/Fvr Blistr
- ☐ Depression
- ☐ Diabetes
- ☐ Diet-Special
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Jaundice
- ☐ Kidney Disease/Stone
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Nervous/Anxious
- ☐ Neuro Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Psychological Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ Inhalants (ie smoking, vaping, ect)
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above needs further clarification, please describe below:

____

____

*****Please answer all questions below. If it does not apply, indicate by answering none.*****

Do you take antibiotic premedication for your dental visits? If yes, please explain.

____

____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician, phone number, and your most recent physical exam:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

____

____

____

____

____

____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

Previous Dentist name and how long have you been a patient there:

____

____

Date of most recent dental exam: ______________

Date of most recent dental x-rays: ______________

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

____

____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) __________

Personal History

By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Are you fearful of dental treatment?
- ☐ Have you had unfavorable dental exerpience?
- ☐ Have you ever has complications form past treatment?
- ☐ Have you ever had difficulty getting numb or had any reactions to local anesthetic?
- ☐ Did you ever have braces, orthodontics or your bite adjusted?
- ☐ Have you had any teeth removed or missing that never developed?

Gum and Bone

- [ ] Do your gums bleed or are they painful when brushing or flossing?
- [ ] Have you ever been treated for gum disease or been told you have lost bone around your teeth?
- [ ] Have you ever noticed and unpleasant taste or odor in your mouth?
- [ ] Is there anyone with a history of periodontal disease in your family?
- [ ] Have you experienced gum recession?
- [ ] Have you ever had any teeth become loose on there own (with out injury) or have difficulty eating an apple?
- [ ] Have you experienced a burning or painful sensation in your mouth not realated to your teeth?

Tooth Structure

- [ ] Have you had any cavities within the past 3 years?
- [ ] Does the amount of saliva in your mouth seem too little or do you have diffuculty swallowing any food?
- [ ] Do you feel or notice any holes on the biting surface of your teeth?
- [ ] Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any parts of your mouth?
- [ ] Do you have grooved or notches on your teeth near the gum line?
- [ ] Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
- [ ] Do you frequently get food caught between your teeth?

Bite and Jaw Joint

- [ ] Do you have problems with your jaw joint? (pain,sounds,limited opening, locking, popping)
- [ ] Do you feel like your lower jaw is being pushed back when you bite your teeth together?
- [ ] Do you avoid chewing gum, carrots, nuts, bagels, baguettes or other hard, dry foods?
- [ ] Have your teeth changed in the last 5 years, become shorter, thinner, worn?
- [ ] Are your teeth more crooked, crowded, or overlapped?
- [ ] Are your teeth developing spaces or becoming more loose?
- [ ] Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?
- [ ] Do you place your tounge between your teeth or close your teeth against your tounge?
- [ ] Do you chew ice, bite nails, use your teeth as tools or to hold objects?
- [ ] Do you clench your teeth in the daytime or make them sore?
- [ ] Do you have any problems with sleep, wake up with a headache or an awareness of your teeth?
- [ ] Do you wear or have you ever worn a bite appliance?

Smile Characteristics

Is there anything about the apperance of your teeth that you would like to change? If yes, please explaine

____

____

Have you ever whitened (bleached) your teeth? ○ Yes ○ No

Have you ever felt uncomfortable or self conscious about the apperance of your teeth? If yes, please explaine

____

____

Have you ever been disappointed with the appearance of previous dental work? If yes, please explaine

____

____

If any of the checked boxes need further explanation, please describe:

____

____

____

____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and had responded accordingly.**

Consent for Services and Financial Policy

We are committed to providing you with the best care possible. As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date treatment is performed. We will estimate your co-payment to the best of our ability. Co-payment for treatment is due at the time treatment is performed unless payment arrangements have been made and approved in advance by our staff. We accept cash, check, Visa, Master Card, Discover or American Express.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this state.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Appointment Cancellation

Your time is valuable. That is why we will be glad to confirm an appointment time with the doctor or hygienists for you. However, should you fail to provide at least 48 hours notice for cancellation of an appointment, we will be unable to fill your space and you will be charged a $75.00 cancellation fee (not covered by insurance).

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Cellphone Contact Authorization

The FCC issued an order under the Telephone Consumer Protection Act of 1991 (TCPA). TCPA rules require a business to obtain an individual's consent prior to calling or sending a text to an individual's cell phone number.

I consent to the dental practice using my cell phone number to contact me regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time. *

☐ Call ☐ Text ☐ Both ☐ None

My cell phone number is: ______________________

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Please be sure to hit submit button once forms are completed. Thank You

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Response Date: __________