**Fletcher Dental ~ 219 North Poplar Street ~ Paris, TN 38242**

**PATIENT INFORMATION**

We are pleased to welcome you to our office. Please take a few minutes to fill out this form completely.

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (first, middle, last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male\_\_\_\_\_\_ Female\_\_\_\_\_\_ Age\_\_\_\_ Circle one: Child Single Married Widowed Divorced

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ext.\_\_\_\_\_\_\_

Our office will contact you and ask you for confirmation of your scheduled appointments.

Which is the best way to reach you? HOME, CELL, TEXT, EMAIL

 1st #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3rd#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give us permission to send you a text reminder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What cellphone provider do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are welcome to communicate with us @ jfletcherdental@gmail.com

Spouse‘s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Person (other than someone in same household)**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_

**If patient is a MINOR CHILD-** Complete This Section

**UNDERSTAND THAT ACCORDING TO TENNESSEE STATE LAW, BOTH SPOUSES ARE RESPONSIBLE FOR MEDICAL AND DENTAL BILLS INCURRED BY EITHER SPOUSE OR THEIR MINOR CHILDREN**

Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information- Please provide a copy of your insurance card**

 **\_\_\_\_\_ NO Insurance \_\_\_\_\_\_\_ Care Credit**

Primary Insurance name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder’s full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder’s full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TN Care insurance will always be filed as your secondary insurance, if you have a primary insurance.**

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**Payment Policy Notice**

**It has become necessary for the practice to require PAYMENT IN FULL on the day treatment is received.**

As a courtesy to you, our office staff will check your insurance coverage and benefits and give you an estimate of what your insurance will cover, please understand this is an estimate. You will be responsible for any services not covered by your insurance. Any deductible and estimated co-insurance must be paid prior to filing a claim with the insurance carrier. It is your responsibility to know your dental benefits as well. It is your responsibility to provide all information requested by your insurance company that they may need to process payment for your claims.

If you have an issue with this, please speak with Melissa, our office manager.

We accept cash, check, VISA, MasterCard and Care Credit for your convenience.

Any balance unpaid after 60 days, will have a $5.oo monthly fee assessed.

All instances of non-payment, regardless of the amount, will be turned over to our attorney or agency for collection. The resulting collection fees, including a one third collection agent fee, and court costs will be added to any outstanding balance.

Once an account has been placed for collection, any further treatment allowed by the practice will be on a CASH basis only.

A $30 fee will be charged to the account for all returned checks. The responsible party is required to make payment in full, with cash, money order, or credit card immediately upon notification from our office.

**Appointment Policy Notice**

We strive to call/text/email you to remind you of your scheduled appointment so that we can keep our cost down and remain productive.

We ask if you are unable to attend your appointment, please give our office staff a 24 hour cancellation notice so that we can offer other patients the allotted time.

We do understand that situations arise beyond your control, however, we appreciate your understanding in this matter.

When a patient misses an appointment without a call to cancel his/her appointment 3 times, we reserve the right to reappoint the patient.

Please understand that we ask that you be prompt and on time and be prepared to pay any charges that will occur.

**Notice of Privacy Policies**

Please read and consider the contents of the Notice of Privacy Practices located with your paperwork. Please understand you are giving your permission to use and disclosure of your personal health information in order to carry out treatment, payment activities, and dental operations. Also understand you have the right to revoke permission.

**Nitrous Oxide Clause**

Nitrous Oxide is a very safe sedative gas inhaled by wearing a mask on your nose. It is important to understand that throughout the procedure, you will need to breathe through your nose and avoid mouth breathing. After breathing through your nose you will typically feel relaxed and less anxious. It does not put you to sleep. At the end of the procedure, you will be placed on 100% oxygen. There is no residual effects form the nitrous oxide.

Nitrous oxide is most often used on children who have a good behavior and is having treatment that can be done in half an hour or less. It is most helpful with minor fillings for slightly anxious children age 4 and older. Children who are uncooperative or are unwilling to follow instructions (e.g. Breathe through your nose) etc. will not be successful with this technique.

Most insurances do not cover nitrous oxide. The charge is $31.00 and this charge will be due at the time of service.

 **AUTHORIZATIONS & UNDERSTANDING OF PAYMENT POLICIES**

I affirm that I have read and understand the above policies and the information that I have given is correct to the best of my knowledge. I understand that it is my sole responsibility to inform the staff members of this office of any change in my medical condition/insurance coverage at each office visit. I authorize Fletcher Dental and staff to perform the necessary dental services I may need and to file claims to my insurance company.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name Signature of Patient/Guarantor Today’s Date

 **Fletcher Dental ~ 219 North Poplar Street ~ Paris, Tennessee 38242**

**Medical History**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approximate date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in Pain Management YES NO If yes, With Whom/Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your current pharmacy you use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When was your last teeth cleaning? \_\_\_\_\_\_ xrays? \_\_\_\_\_

Your current physical health is \_\_\_\_\_good \_\_\_\_\_fair \_\_\_\_\_poor

Do you use tobacco products? \_\_\_\_\_yes \_\_\_\_\_no

Women: Are you currently pregnant or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies- None that you are aware of (NKDA)**

List all DRUG allergies - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies to metals/jewelry? YES NO

Do you have allergies to LATEX? YES NO

**List all medications you are taking \_\_\_\_\_\_ NONE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you (or have you in the past) take bisphosphonates (such as Boniva, Fosamax, Actonel, Aredia or Zometa)? YES NO

**Do you have, or have you had, Check/date any of the following?** \_

 \_\_\_\_**NONE**

\_\_\_\_\_Kidney Disease \_\_\_\_\_Abnormal bleeding \_\_\_\_\_Tuberculosis

\_\_\_\_\_Epilepsy \_\_\_\_\_Diabetes \_\_\_\_\_Emphysema

\_\_\_\_\_Blood Transfusions \_\_\_\_\_Fainting Spells \_\_\_\_\_Seizures

\_\_\_\_\_High Blood Pressure \_\_\_\_\_HIV/Aids \_\_\_\_\_Liver Disease

\_\_\_\_\_Healing Complications \_\_\_\_\_Anemia \_\_\_\_\_Asthma

\_\_\_\_\_Thyroid Problems \_\_\_\_\_Venereal Disease \_\_\_\_\_Glaucoma

\_\_\_\_\_HEP A \_\_\_\_\_HEP B \_\_\_\_\_HEP C

Please list dates/information \*\*Requires Pre-Medication

\_\_\_\_\_\_\_\_\_Cancer \_\_\_\_\_\_\_\_Heart Attack \_\_\_\_\_\_\_\_Stroke

\_\_\_\_\_\_\_\_\_Radiation Treatment \_\_\_\_\_\_\_\_Pacemaker \_\_\_\_\_\_\_\_Heart Surgery

\_\_\_\_\_\_\_\_\_\*\*Artificial Valves \_\_\_\_\_\_\_\_\*\*Artificial Joints \_\_\_\_\_\_\_\_\*\*Infective Endocarditis

List all surgical operations/date and any other health issue/date?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X-Signature of Patient/Guarantor: Today’s Date: