FLETCHER FAMILY DENTISTRY

FletcherFamilyDentistry.com info@fletcherfamilydentistry.com
PO Box 2139 | 235 Saint John Rd, Ste 110 • Fletcher, NC 28732 (828)654-7450

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

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

******* Fletcher Family Dentistry automatically sends emails and text messages to confirm appointments. Please check ONLY if you DO NOT wish to have email or test messages sent *******

☐ **NO - I do not wish to be contacted by email or text messages**

Whom may we thank for referring you to our practice?

_____

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

_____

_____

Employment Information

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

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than the patient, or you are the parent/guardian of the patient

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

Name: _____ (Last) _____ (First) ___ (M) _____ (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)

☐ **I do not have dental insurance and I am therefore prepared to pay in full for my appointment today**

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (M)

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:

☐ **I will inform the office of any changes in my insurance coverage**

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.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

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

What is your immediate concern?

_____

_____

Personal History- check all that apply:

☐ Are you fearful of dental treatment
☐ Had complications from past dental treatment
☐ Had trouble getting numb or any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You have experience dry mouth or a burning sensation in your mouth

Gum and bone- check all that apply:

☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)

Tooth Structure- check all that apply:

☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food frequently gets trapped between any teeth
☐ You feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth
☐ Any teeth have grooves or notches on your teeth near the gum line

Bite and Jaw Joint- check all that apply:

☐ Have problems with your jaw joint- (pain, sounds, limited opening, locking or popping)

☐ You have difficulty chewing

☐ You clench or grind you teeth

☐ You wear or have worn a bit appliance: Night Guard/ NTI

☐ Have seen noticeable difference in your teeth becoming more crooked, crowded, overlapped, shorter or thinner/worn

Smile Characteristics- check all that apply:

☐ Have you ever whitened or bleached your teeth

☐ Have you felt uncomfortable or self-conscious about the appearance of your teeth

☐ Is there anything about the appearance of your teeth that you would like to change?

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

_____

_____

_____

_____

Consent for Services and Financial Policy

Part of our mission at the office of Fletcher Family Dentistry is to provide you with cost effective, state-of-the-art dental care. It is our goal to assist you in obtaining and maintaining the highest level of personal dental health available today. In order to maintain an enduring partnership between our patients and practice, we have developed the following policy to serve as an agreement between the responsible party and our practice.

We want you to have the smile you desire and deserve!

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED; WE ACCEPT THE FOLLING PAYMENT OPTIONS

PAYMENT OPTIONS:

*For your convenience, we accept Cash, Check, Visa, MasterCard, Discover, or American Express

*Care Credit: specializes in helping patients finance larger dental cases. No down payment is required, and payments can be made up to 12 months with no interest rates if amount is over $250.00

MAJOR SERVICE:

Payment in full is required at the time service. However, we will make payment arrangements for major procedures. Lab related services (crown, bridge, partial, denture or bleaching kits) for both cash or insurance patients require 50% at the preparation date and 50% at the completion date.

USUAL AND CUSTOMARY FEES:

Our fees are what are usual and customary in our area and designated by our preferred insurance community, not what your insurance plan feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participating provider (PPO) with your insurance company.

INSURED PATIENTS:

Dental insurance can help aid patients with the cost of healthcare, however, it was never meant to provide 100% coverage for all services that you may want or need. Insurance does not dictate what we can provide for a patient. Your policy is a contract between you, your employer, and your insurance company. There is no guarantee that services will be covered. You must provide us with a copy of your dental insurance card. If you have any changes in your insurance information you are responsible for giving us the correct information. We will attempt to verify that you have coverage with this insurance. If we cannot verify your insurance, you will need to pay for your visit in full and we will provide you with the proper paperwork to fil your claim. We can only verify your insurance coverage and basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you. Insurance companies do not guarantee us payments, so any fees stated to you are estimates only. You may have your services pre-authorized by your insurance company. This will tell us exactly what your insurance company will pay for services and what your portion of the services will be, but a disadvantage is that treatment is delayed. This in itself could complicate matters as problems may worsen. You are responsible for any

monies that your insurance does not cover. I.E.: Deductibles, co-insurance/co-payment, alternate benefits, denied claims due to missing tooth clauses, frequency of services, age limitations, plan limitations, cosmetic services, cost of parts, or lab fees, etc.

EMERGENCIES:

The office is closed on Wednesdays, Weekends, and Major Holidays. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at time of services unless other arrangements are made. If you have an after-hours emergency simply call the office at 828-654-7450 to receive the after hours number which will allow you to leave a message for the dentist.

CANCELLATION POLICY:

A Specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. We ask that you provide 24 hrs. notice of a change or cancellation of an appointment. A $25/hr. cancellation fee will be assessed upon the second broken appointment. We understand that there are unavoidable situations and inconveniences in everyone's life, but three missed appointments without proper notice will result in dismissal from the practice.

DIAGNOSTIC X-RAYS:

An oral evaluation warrants that we have recent diagnostic x-rays to detect decay, bone loss and hard tissue abnormalities on all patients. We will take a panoramic x-ray and bitewing x-rays or a full mouth series of x-rays on all New Patients to facilitate our initial evaluation. If you have a panoramic x-ray or full mouth series of x-rays that have been taken within the last five (5) years by another dentist, we will be happy to request those x-rays and save you the additional expense of taking new films. Panoramic x-rays or a full mouth series of x-rays will be updated every five years to evaluate bone health and bitewing x-rays will be taken annually to detect inter-proximal decay.

RETURNED CHECKS:

There will be a returned check fee of $35 for any returned check. This fee may increase depending on the bank's charges. This fee will be added to the outstanding balance and may incur finance charges if not paid within the 30 day grace period.

ALL PATIENTS:

If your account is 90 days or more delinquent, you must speak to the office manager prior to further treatment. If your account becomes 90 days past due and you have not contacted us for payment arrangements, your account will be sent to collections. In this event, there will be a 25% processing and handling fee charged to your account. Ultimately, it is the patient or the patient's legal guardian, who is responsible for paying, in-full, all fees incurred through our office, regardless of any other party/agency that might be involved in your payment arrangement. We expect patients to make payments as arranged in a timely manner.

In case of a minor child or dependent patient, the parent or guardian presenting the child to our office will be considered to be the person responsible for the account. Our office cannot enter into negotiating benefits that might be due from an absent parent or legal guardian.

☐ *** 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.**

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

HIPAA Acknowledgement

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

☐ * **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.**

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 Fletcher Family Dentistry 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. This will serve as my electronic signature.**

Signature _____ **Date** _____

Response Date: ____/____/_____