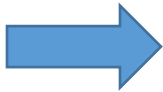


***** Patient Information *****

First Name: _____ MI: _____ Last Name: _____
Preferred Name: _____ Birthdate: ____/____/____ Sex: Male Female Other
Social Security #: _____ Status: Married Single Other: _____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone: Home Cell _____ Work: _____
Email: _____
Emergency Contact: _____ Emergency Contact #: _____
Referred By: _____



Fletcher Family Dentistry automatically sends emails and text messages to confirm appointments.
Please check ONLY if you DO NOT wish to have email or text messages sent
 NO – I do not wish to be contacted by email or txt messages.

***** Responsible Party or Policy Holder for Insurance: (If different from Patient) *****

First Name: _____ MI: _____ Last Name: _____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Birthdate: ____/____/____ Social Security #: _____ Relationship to Patient: _____
Phone: Home Cell _____ Work: _____ Ext: _____
Email: _____

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

***** Dental Insurance Information *****

(Always bring current Insurance card to appointments)

Name of Insured: _____ Birthdate: ____/____/____
Relationship to Patient: Spouse Child Other _____ Insured is: Patient Responsible Party Both
Name of Insurance company: _____
Member ID: _____ Group #: _____ Status: Full time Part time
Employer: _____ Employer Phone #: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

- I WILL INFORM THE OFFICE OF ANY CHANGES IN MY INSURANCE COVERAGE
- 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, AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

Patient's Signature / Responsible Party

Date