Fletcher Family Dentistry
235 Saint John Road Suite 110 ☙ Fletcher, NC ☙ 28732 ☙ Phone: 828.654.7450 ☙ Fax 828.654.8665

*** 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**