Chad T. Fletcher D.D.S., P.A
1110 N. Buckner Blvd. Suite 102
Dallas TX 75218

Patient Information

Patient Name: _____ Date _____
Last First Middle

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other_____

Social Security #_____ Date of Birth _____

Preferred Contact Number _____ _____
Main Number Optional Number

Address _____
Street Apartment

_____
City State Zip Code

Email Address_____

Referred By: _____

Health Information

Date of Last Dental Visit _____ Reason for this visit_____

Have you ever had any of the following? Please check those that apply:

☐AIDS
☐Allergies_____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy

☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Hay Fevers
☐Head Injuries
☐Heart Disease
☐ Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease

☐Liver Disease
☐Mental Disorder
☐Nervous Disorder
☐Pacemaker
☐Pregnancy
Due Date_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problem

☐Stroke
☐Tuberculosis
☐Tumor
☐Ulcers
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy
Other
☐_____
☐_____

- Have you ever had any complications following dental treatment? ☐Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
  If yes, Please explain:_____
- Are you under the care of a physician? ☐Yes ☐No
  If yes, please explain:_____
- Name of your Physician:_____ Phone Number_____
- Do you have any health problems that need further clarification? ☐Yes ☐No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes on my health history, I will inform the doctors at the next appointment without fail.

_____ Date _____
Signature of patient, Parent Guardian

Dr. Chad T. Fletcher
1110 North Buckner Blvd., Ste. 102
Dallas, TX 75218

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
* Obtaining payment from third party payers (e.g. my insurance company)
* The day to day operations of your healthcare practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the more current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree with these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of_____,20_____

Print Patient Name:_____
Relationship to Patient:_____
Signature:_____

Dr. Chad T. Fletcher
1110 North Buckner Blvd., Ste. 102
Dallas, TX 75218
214-328-9173

PAYMENT POLICY

To avoid any misunderstandings regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees at the time of service. Our patients may use Cash, Check or Credit Card to pay their balances.

We **do not** render our services on the basis of what our patients' insurance companies will or will not cover. We render our services based on our patients' oral health and the best treatment to maintain and/or restore our patients' oral health.

The portion that is charged to our patient is the **estimated** amount due from the patient based on what the insurance company has conveyed over the telephone to our office staff. However, if the insurance company does not cover for all fees, **the patient is responsible for any and all balances remaining.**

We will file the primary insurance as a courtesy; however, the patient is responsible for all the fees incurred. **In addition to all other remedies patient shall pay Dr. Chad Fletcher's expenses and attorney fees incurred to collect money owed to Dr. Chad Fletcher from patient under these terms.**

Patient Name: _____

Signature: _____

Today's Date: _____