

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No If Yes, Complete the Following:

Name of Insured _____ Relationship to Patient _____
Insured's Birthdate _____ Insured's Soc Sec # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Insurance Company Phone # _____
How Much is your Deductible? _____ Max. Annual Benefit _____ How Much Have You Used? _____
Can you Choose your own dentist on this Insurance Plan? Yes No

Who may we thank for referring you? _____
What is the reason for today's visit? _____
Date of last dental visit _____
Name of former Dentist _____ Phone _____

Authorization Release

I request Dr. Fletcher to provide dental care for myself, my child, and or my dependent. I authorize this office to release any dental records to third party payers and/or other health practitioners. I understand insurance carriers may pay directly to Fletcher, D.D.S. I understand that dental benefits and my patient portion are estimated and my dental insurance may change, have special clauses or wait periods. I understand my insurance may pay less then estimated and that it may pay nothing at all. I agree to be responsible for payment of all service rendered on my behalf or my dependents behalf, regardless of insurance.

Signature of patient or parent of minor

Date

Financial Arrangements

We reserve appointment times just for you. If you are unable to keep the appointment you have made, please notify us immediately! You will be charged without giving us 24 hours notice.

Your patient portion is expected IN FULL either by cash, check or charge card.

Any remaining balance accrues finance charges after 25 days. If entire new balance is not paid within 25 days of the monthly billing date a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Dr. Fletcher being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred.

Signature of patient or parent of minor

Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any question at anytime, please ask - we are always happy to help.