Patient-First Dental Care
Gayle J. Fletcher, DDS
1336 League Line Rd. #400
Conroe, TX 77304

Phone: (936) 856-9969
Fax: (936) 856-9970
info@patientfirstdental.net
www.PatientFirstDental.net

New Patient Registration

Patient Last Name _____ Patient First Name _____

Address _____ City _____ State _____ Zip Code _____

Patient SSN# _____ ☐ Male ☐ Female

Patient Birthday _____ ☐ Single ☐ Married ☐ Divorced ☐ Widow

By providing your contact information below, you agree we may contact you.

Home Phone _____ Cell/Text _____ Work Phone _____

Email _____

Emergency Contact _____ Phone _____

Reason for visit? _____ How did you hear about us? _____

- Is the patient covered by dental insurance? ❑ Yes ❑ No

Responsible Party Registration

Guardian/Responsible Party Last Name _____ Guardian/Responsible Party First Name _____

Guardian/Responsible Party SSN# _____ Guardian/Responsible Party Birthday _____ ❑ Male ❑ Female

Home Phone _____ Cell/Text _____ Work Phone _____

Medical History

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Artificial Joints
- ❑ Cancer
- ❑ Diabetes
- ❑ Erythromycin Allergy
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Latex Allergy
- ❑ Low Blood Pressure
- ❑ Periodontal Disease
- ❑ Radiation head/neck
- ❑ Seizures
- ❑ Sulfa Allergy
- ❑ Allergies (Seasonal)
- ❑ Arthritis
- ❑ Aspirin Allergy
- ❑ Chemotherapy
- ❑ Dizziness
- ❑ Excessive Bleeding
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Pregnant (Currently)
- ❑ Respiratory Problems
- ❑ Stomach Problems
- ❑ Alzheimers/Dementia
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Codeine Allergy
- ❑ Drug/Alcohol Abuse
- ❑ Fainting
- ❑ Heart Surgery/Condition
- ❑ Kidney Disease
- ❑ Local Anesthetic Allergy
- ❑ Nervous/Depression
- ❑ Penicillin Allergy
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Ulcers

Current Medications:

If you have a list, we are happy to make a copy.

_____ _____

_____ _____

_____ _____

_____ _____

Additional Medical Concerns (not already listed):

_____ _____

Doctor Information

_____ _____

General Physician Phone

_____ _____

Cardiologist Phone

_____ _____

Orthopedic Surgeon Phone

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Gayle J. Fletcher, DDS, PA**. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

- *We will use the information you have provided to contact you to confirm dental appointments, discuss treatment, convey information about your dental health and billing information. This may include, but not limited to, emails, text messages, phone communications, voice mails and mailed information.*
- *With your verbal permission, while interacting with our team, we may take photos, videos and/or other media of/with you to share on social media platforms such as but not limited to Facebook and Instagram.*
- *We will use the information you have provided to contact your insurance company and process dental claims on your behalf.*

I AUTHORIZE, GAYLE J. FLETCHER, DDS, PA TO USE MY INFORMATION TO CONTACT ME AS STATED ABOVE, SHARE PHOTOS, VIDEOS OR OTHER MEDIA ON SOCIAL PLATFORMS AND TO CONTACT AND PROCESS DENTAL CLAIMS ON MY BEHALF. I UNDERSTAND I MAY REVOKE THIS RELEASE AT ANY TIME BY SUBMITTING A WRITTEN REQUEST.

To Be Signed Digitally

_____
Please ***print*** your name

_____
Please ***print*** your name

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer

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Written Financial Policy

Thank you for choosing Gayle J. Fletcher, D.D.S., PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Visa, Mastercard, Discover Card or Cash, Check

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check in advance for treatment plans of $1000 or more.

- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Gayle J. Fletcher, D.D.S., PA requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments of $1000 or more, on a case by case basis. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $ 5,000.00 or more, a 1/3 deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

Gayle J. Fletcher, D.D.S., PA charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Please review the information regarding our office financial policies. This acknowledgement will be signed electronically.

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Any portion which your insurance does not pay will become the responsibility of the patient and/or the insurance subscriber. The insurance will not guarantee how much they will pay; therefore all quotes for anticipated payments are estimates only.