# PATIENT INFORMATION

**Patient Name**_______________________________________Home Phone_________________________
Address____________________________________________Work Phone_________________________
City,State__________________________ Zip Code_______Mobile Phone________________________
Email address__________________________________________________
Employer Name, Address, Phone_________________________________________________________
Birth date___________________ Age______ SSN________________Marital Status: S M D W
*Person to contact in case of emergency:* ____________________*Relationship*_____________
*Address:* ____________________________________________ *Phone:*______________________

**SPOUSE, PARENT** (if patient is a minor) **INFORMATION:**
Name _________________________________SSN ______________Home Phone________________
Address____________________________________________________ Work Phone________________
City,State__________________________ Zip Code________________ Mobile/Pager_______________
Relationship to patient _________________________Email address_____________________________
Employer Name, Address, Phone_________________________________________________________
Birth date ___________________Age ______SSN_______________ Marital Status: S M D W

**INSURANCE INFORMATION:**
**1. Primary Carrier Name, Address & Phone**_______________________________________________
Name of insured person ____________________Date of Birth_________________________________
Insurance ID# or SSN_________________________________________________________________
Employer name, address & phone_______________________________________________________
**2. Secondary Carrier Name, Address & Phone**_____________________________________________
Name of insured person____________________Date of Birth_________________________________
Insurance ID# or SSN_________________________________________________________________
Employer name, address & phone_______________________________________________________

**REASON FOR THIS VISIT:**
- ☐ Routine check-up
- ☐ Emergency/Pain, please describe____________________________________________

**DATE OF LAST DENTAL VISIT** _______________________________________________________
**X-RAY'S TAKEN RECENTLY AT ANOTHER OFFICE** ____________________________________
**REFERRED TO US BY:** _______________________________________________________________

# PATIENT MEDICAL HISTORY

**Patient's Name:** **Today's Date:** **Date of Last Visit:** **Date of Med. History:**

**Pharmacy:** **Pharmacy Phone:**

**Physician Name:** **Physician Phone:**

---

**For Office Use Only**

**Medical Alerts:**

**Sex:**

**If female please answer the following:**

| Y | N | |
|---|---|---|
| ☐ | ☐ | Are you taking Birth Control Pills? |
| ☐ | ☐ | Are you pregnant? If Yes, # of weeks |
| ☐ | ☐ | Are you nursing? |

**Please answer the following:**

| Y | N | | |
|---|---|---|---|
| ☐ | ☐ | Do you smoke or use tobacco? | Height: |
| **For Office Use Only** | | BP Heart Rate: | Weight: |

| Y | N | Conditions | Y | N | Conditions | Y | N | Conditions |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Angina Chest Pains | ☐ | ☐ | Alcohol Abuse | ☐ | ☐ | CPAP Use |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Drug Abuse | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Heart Conditions | ☐ | ☐ | HIV+ AIDS | ☐ | ☐ | Vertigo |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | HPV | ☐ | ☐ | Surgery Last 2 Yrs. |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Vision Problems |
| ☐ | ☐ | Pace Maker | ☐ | ☐ | Hepatitis B | ☐ | ☐ | Other |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Hepatitis C | | | |
| ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Hepatitis D | | | |
| ☐ | ☐ | Asthma/Difficulty Breathing | ☐ | ☐ | Cosmetic Surgery | Y | N | **Allergies** |
| ☐ | ☐ | Stroke | ☐ | ☐ | Kidney Problems | ☐ | ☐ | Aspirin |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Liver Disease | ☐ | ☐ | Codeine |
| ☐ | ☐ | Bleeding Disorders | ☐ | ☐ | Migraine Headaches | ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Seizures | ☐ | ☐ | Erythromycin |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Osteoprosis Osteopenia | ☐ | ☐ | Jewelry |
| ☐ | ☐ | Artificial Joints | ☐ | ☐ | Psychiatric Treatments | ☐ | ☐ | Latex |
| ☐ | ☐ | Cancer | ☐ | ☐ | Seasonal Allergies | ☐ | ☐ | Metals |
| ☐ | ☐ | Skin Cancer | ☐ | ☐ | Sinus Problems | ☐ | ☐ | Penicillin |
| ☐ | ☐ | Chemo/ Radiation | ☐ | ☐ | Thyroid Problems | ☐ | ☐ | Tetracycline |
| ☐ | ☐ | Dermatology Disorder | ☐ | ☐ | Snoring Loudly | **Other** | | |
| ☐ | ☐ | Cold Sores | ☐ | ☐ | GERD/Acid Reflux | | | ____________ |
| ☐ | ☐ | Shingles | ☐ | ☐ | Difficulty Sleeping | | | ____________ |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Sleep Apnea | | | ____________ |

**Medications:**

| | | |
|---|---|---|
| | | |

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
**If yes, please describe below...**

**Notes:**

**Signature:** ______________________________ **Date:** ______________

(If Under 18, Parent or Guardian Signature Required)

# CONSENT FORM

John G. Fletcher, DMD, PLLC

1. I give my consent to use local anesthetics, pain medications, or antibiotics if deemed necessary for the completion of any dental treatment.

2. I understand that whenever a tooth is extracted, there is the possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible although rare, that the paresthesia would be permanent.

3. I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success it cannot be guaranteed. Occasionally a tooth treated by root canal therapy may later experience acute infection. It may then require re-treatment, surgery or (rarely) extraction. Restoration with a crown should almost always follow root canal treatment. Sometimes a strengthening post in the tooth may also be indicated.

4. I understand that preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future.

5. Women taking birth control medication should be aware that when taking antibiotics for infections there is a decreased effect of the contraceptive and therefore an increase the chance of becoming pregnant.

6. I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.

7. I realize that any costs incurred during treatment are my responsibility. I realize that my insurance (if applicable) may help pay part of my treatment and that any estimates quoted to me are only estimates. I will be ultimately responsible for anything left unpaid by the insurance company. I understand that I may be charged interest on any unpaid balance. I understand that if I am turned over to collections, I will be responsible for any collection, attorney or court fees incurred by this practice.

8. I understand that if I fail to give at least 48 hours notice to cancel a scheduled appointment that I may be charged a “broken appointment fee”.

9. I understand that any images, radiographs (X-rays), photographs and records are the property of the dentist by law. (ARS 32-1264) I do have the legal right to view or receive copies of my records at any time. A fee may be charged for any duplication or transfer of said radiographs or records.

10. I have received a copy of this office’s “Patient Record Privacy Policy” and know that at any time I may view it at www.drfletcherdmd.com or receive another copy by asking for it. I give this office my consent to share my Medical/Dental information only as outlined in this policy. I know that I can revoke that permission at any time by requesting this and signing the appropriate form.

Signed ______________________________ Date _________

Patient, parent or guardian

---

**For Office Use Only**

---

We attempted to obtain written **acknowledgement** of receipt of our “Notice of Privacy Practices” and general **consent**, but these could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify

# Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
**Please review it carefully.**

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |

*continued on next page*

## Your Rights *continued*

| | |
|---|---|
| **Ask us to limit what we use or share** | • You can ask us **not** to use or share certain health information for treatment, payment, or our operations.<br>  • We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br>  • We will say "yes" unless a law requires us to share that information. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**<br>• We will not retaliate against you for filing a complaint. |

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>• Contact you for fundraising efforts<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you. | ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. | ***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities. | ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as:<br>• Preventing disease<br>• Helping with product recalls<br>• Reporting adverse reactions to medications<br>• Reporting suspected abuse, neglect, or domestic violence<br>• Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | • We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>• For workers' compensation claims<br>• For law enforcement purposes or with a law enforcement official<br>• With health oversight agencies for activities authorized by law<br>• For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**

JOHN G. FLETCHER
DMD, PLLC
FAMILY & COSMETIC DENTISTRY

TAKE OUR...

# Smile Assessment

AND SEE IF YOU MIGHT BE A CANDIDATE FOR AN ENHANCED SMILE

**Name:**_______________________________________________ **Date:** ____________________

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are you comfortable showing your teeth when you smile? |
| ☐ | ☐ | Are you happy with the appearance of your teeth? |
| ☐ | ☐ | Do you have unsightly crowns or fillings? |
| ☐ | ☐ | Are your teeth sensitive to hot or cold? |
| ☐ | ☐ | Do you feel your teeth are too long or too short? |
| ☐ | ☐ | Do you like the color of your teeth? |
| ☐ | ☐ | Are you interested in replacing missing teeth? |
| ☐ | ☐ | Are you familiar with the benefits of dental implants? |
| ☐ | ☐ | Are your gums receding? |

**What is holding you back from your perfect smile?**

- ☐ Fear
- ☐ Time
- ☐ Cost
- ☐ Other: ____________________________________________________________

____________________________________________________________

2600 E. Southern Ave. • Suite B-1 • Tempe, AZ 85282 • **Phone:** 480-839-4550 • **Fax:** 480-897-8407 • **www.DrFletcherDMD.com**