JFK DENTAL CARE
Dr. Stephanie Flaherty & Dr. Julie Routon
5125 JFK Blvd.
North Little Rock, AR 72116

Patient Information

Patient Name : _____ Date _____
Last **First** **MI**

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other**_____

Social Security # _____/_____/_____ **Birth Date:** _____/_____/_____

Email: _____ **Driver's License #:** _____

Phone (Home): _____-_____ **(Work):** _____-_____ **Ext:** _____**Cell Phone:** _____-_____

Address: _____
Street **Apartment #**

_____
City **State** **Zip Code**

Employer Name: _____

Address: _____
Street **City** **State** **Zip Code**

Health Information

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

☐ AIDS

☐ Allergies - Sulfa
-Penicillin
- Codeine
-Latex
-Other-
_____
_____.

☐ Anémia

☐ Arthritis

☐ Artificial Joints

☐ Asthma

☐ Blood Disease

☐ Cancer

☐ Diabetes

☐ Dizziness

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting

☐ Growths

☐ Drug Addictions

☐ Heart Disease

☐ Heart Murmur

☐ Heart Stints

☐ Blood Thinners

☐ Hepatitis A, B or C

☐ High Blood Pressure

☐ HIV

☐ Venereal Disease

☐ Liver Disease

☐ Kidney Disease

☐ Mental Disorders

☐ Mitral Valve Prolapse

☐ Nervous Disorders

☐ Pre-Med

☐ Pacemaker

☐ Pregnancy
Due date: _____

☐ Radiation Treatment

☐ Respiratory Problems

☐ Rheumatic Fever

☐ Rheumatism

☐ Scarlet Fever

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Tuberculosis

☐ Tumors

☐ Ulcers

Other:

☐ _____

☐ _____

Please list any medications you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

Whom may we thank for referring you to our practice? _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone_____

Do You Have Insurance? ☐ Yes ☐ No
*****If "YES" please complete information below!!*****

Insurance Company _____

Policy Holder's Name: _____

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other** _____

Policy Holder's Social Security #: _____/_____/_____ **Policy Holder's Birth Date:** _____/_____/_____

Insurance Address: _____ **Insurance ID#**_____
Street

_____ **Group #** _____
City **State** **Zip Code**

Policy Holder's Employer Name: _____ **Policy Holder's** Home **Phone #**____-____-_____ **Cell** ___-____-_____

DISCLOSURE OF HEALTH INFORMATION (HIPPA)

***(Please Print the Following Information) ***

Name:_____

Telephone:(_____) _____-_____

Social Security #:_____-_____-_____ DOB:_____/_____/_____

(Please Read the Following Statements Carefully) **

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatments, payment activities, and health care operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies his consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

By signing this form, you are indicating you have read the information above and are giving your Consent for JFK Dental Care to use and disclose your protected health information to carry out treatment, payment activities and health care operations:

Signature:_____ Date:_____/_____/_____

FINANCIAL AGREEMENT

Thank you for choosing and trusting JFK Dental Care for all your dental needs. It is our policy to have a definite agreement between you, the patient, and this office concerning payment of the fees for services rendered. Prior to treatment, you will be advised of the approximate cost. For convenience, we accept Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If major dental work is required, it is understood that at least HALF of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. However, remember that this is only an estimate. The actual out of pocket cost could be more or less than the original estimated amount. Any dental service performed without previous financial arrangements or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE

Our office will file any claims to your insurance company as a COURTESY to you. You will be responsible for any deductible and copayment of the total charges at the time of service. The quote given to you in reference to your insurance benefits is an estimate only. Insurance benefits can change, as the policy holder you are responsible to be aware of those changes. I understand that if my insurance company has not paid the FULL BALANCE of the claim within 60 days that I will be required to pay the balance in FULL, in consideration for the professional services rendered to me, or at my request, by the Doctor. I understand that my insurance policy is an agreement between myself and the insurance company, not JFK Dental Care and your insurance company. I agree to pay for those services in full. I further agree to pay any costs and reasonable attorney fee if suit is instituted hereunder. I grant my permission to you to telephone me at home or work to discuss matters related to this form. After two consecutive missed appointments, it is our policy not to reschedule you for any further appointments until a prepayment has been made on future appointments scheduled. There is also a $29.00 charge for all returned checks for which the balance of the check and return check fee will be paid for in cash or money order only.

DELINQUENT ACCOUNTS

All accounts deemed delinquent and placed in the hands of a collection agency are subject to penalties. I agree to pay all attorney fees, collections agency fees, and all other costs under Arkansas law. If a delinquent account is turned over to collections, all future appointments must be paid up front before treatment is rendered.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICY AGREEMENT

Name : _____

Signature : _____ Date : _____

Informed Consent Form for General Dental Procedures The patient has the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence. I understand that dentistry is not an exact science, and that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all your concerns to your satisfaction before commencing treatment.

Patient Name : _____

Patient Signature : _____ Date_____

Parent/legal guardian signature : _____ Date _____

Informed Consent Form for General Dental Procedures

A patient has the right to accept or reject dental treatment recommended by their dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence. I understand that dentistry is not an exact science, and that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all your concerns to your satisfaction before commencing treatment.

Patient Name : _____

Patient Signature : _____ Date_____

Parent/legal guardian signature : _____ Date _____

MISSED APPOINTMENTS AND NO SHOWS

JFK Dental Care understands that plans can change. However, a 24-hour notice is greatly appreciated so we have time to place another patient in your time slot. I understand that a fee of $50 per hour of treatment time scheduled for your reserved appointment will be charged if I do not give at least a 24-hour notice.

*** All cancellations & appointment changes must be done by calling our office and speaking to a team member. Leaving a message or texting is not a sufficient form of notice. ***

I have read and understand the terms of the cancellation policy.

Signature : _____ Date : _____