JFK DENTAL CARE
5125 JFK Blvd.
North Little Rock, AR 72116
Patient Information

Patient Name: _____Date _____/_____/_____
Last First MI

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other Birth Date _____/_____/_____

Parent/Guardian: _____ Birth Date _____/_____/_____
Last First MI

Social Security # _____/_____/_____ Driver License # _____ State _____

Phone (Home) (____)_____-_____ (Work) (____)_____-_____ Ext _____ (Cell) (____)_____-_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Email Address: _____

Health Information

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

☐AIDS	☐Growths	☐Nervous Disorders	☐Tumors
☐Allergies _____	☐Drug Addictions	☐Pre-Med	☐Ulcers
_____	☐Heart Disease	☐Pacemaker	☐Venereal Disease
☐Anemia	☐Heart Murmur	☐Pregnancy	☐Codeine Allergy
☐Arthritis	☐Heart Stints	Due date: _____	☐Penicillin Allergy
☐Artificial Joints	☐Blood Thinners	☐Radiation Treatment	☐Sulfa Allergy
☐Asthma	☐Hepatitis A, B, or C	☐Respiratory Problems	**Other:**
☐Blood Disease	☐High Blood Pressure	☐Rheumatic Fever	☐_____
☐Cancer _____	☐HIV	☐Rheumatism	☐_____
☐Diabetes	☐Kidney Disease	☐Scarlet Fever	☐_____
☐Dizziness	☐Latex Allergy	☐Sinus Problems	☐_____
☐Epilepsy	☐Liver Disease	☐Stomach Problems	☐_____
☐Excessive Bleeding	☐Mental Disorders	☐Stroke	☐_____
☐Fainting	☐Mitral Valve Prolapse	☐Tuberculosis	☐_____

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 Holders Name: _____

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

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

Phone (Home) (____)_____-_____ (Work) (____)_____-_____ Ext _____ (Cell) (____)_____-_____

Address: _____

Street Apartment #

_____

City State Zip Code

Employer Name: _____

Address: _____

Street City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Signature of Patient, Parent, Guardian, and/or Responsible Person

Party: _____Date: _____/_____/_____

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

*****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 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: _____/_____/_____

***If you would like a copy of this signed document, please inform someone at the front desk.**

Thank you for choosing JFK Dental Care as your Dental Care Specialist.

Visit our website @ Jfkdentalnlr.com