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
  - -Doxycycline
- 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
- ☐ Currently pregnant
  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: ______________________________________
Street

____
City State Zip Code

Insurance ID#______________________

Group # _______________________

Policy Holder's Employer Name: ___________________________________

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

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

Party____**Date:** ______/______/______

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:______/______/________

Your time is valued and we strive to be on time for your appointment. Our time is also important; therefore, we require at least 24 hours cancellation notice. If you cancel or do not show up for your reserved appointment you will be charged a $50.00 cancellation fee. The second missed appointment is a $100.00 cancellation fee and the third time may result in being dismissed from the practice.

Signature:____

FINANCIAL AGREEMENT

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 <u>Cash, Check, Visa, MasterCard, Discover and American Express.</u> All Emergency dental services or any dental service performed without previous financial arrangement with office manager must be paid for at the time of service.

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. All financial arrangements must be made prior to treatment with the office manager. Financial responsibility on the part of each patient will be determined before treatment. Any dental service preformed without previous financial arrangements or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE

Insurance plans are accepted after verification. There are now insurance companies that only have automated systems. There are some companies that will fax a printout with a disclaimer that this is not a guarantee of benefits. Our office will file any claims to your insurance company as a COURTESY to you. You will be responsible for any deductible and co-payment 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. If your insurance plan has not paid the FULL BALANCE within 45 working days you will be required to pay your balance in FULL.

In consideration for the professional services rendered to me, or at my request, by the Doctor, 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.

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

Signed____ Date__________________________