NEW PATIENT INFORMATION SHEET

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)

Patient Goes by: _____

Permanent Address

City State Zip Code

Date of Birth Age Sex Social Security Number

Home Phone Work Phone

Guarantor Cell Phone #

Are You ☐ Actively Employed ☐ Retired
Student ☐ Full-Time ☐ Part-Time
Are you Single_____Married_____ Widowed _____ Divorced_____

E-mail Address

Employer / School

Emergency Contact / Relationship

Emergency Contact Phone Number

Have we seen anyone in your family before? Whom?

Referred By:

Dentist:

Pediatrician or Family Doctor:

FILL IN IF PARENT IS RESPONSIBLE

Father's Name (First, Middle, Last)

Soc Security Number Date of Birth

Employer Work #

Mother's Name (First, Middle, Last)

Soc Security Number Date of Birth

Employer Work #

FILL IN FOR HUSBAND OR WIFE

Spouse's Name Date of Birth Soc Security Number

Employer

Work Phone Cell Phone

DENTAL INSURANCE

Name of Insurance Company Insurance Phone Number

Name of Policy Holder

Insurance Address City State Zip

Policy Number Group Number

MEDICAL INSURANCE

Name of Insurance Company Insurance Phone Number

Name of Policy Holder

Insurance Address City State Zip

Policy Number Group Number

SECONDARY INSURANCE

☐ Yes ☐ No

Please allow us to copy all your insurance cards

READ AND SIGN

Payment is expected on the day services are provided regardless of insurance coverage. We make every effort to keep down the cost of your surgical case. You can help by paying upon completion of each visit. Prior to any procedures being performed, a financial assessment will be reviewed with you by our financial staff. If you have medical or dental insurance, we will be happy to verify coverage of proposed procedures with you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Insurance companies vary in their usual and customary rates and their percentage of payment. It is your responsibility to pay your estimated co-insurance amount before surgery and any other balance remaining after insurance responds. Your signature on file is my authorization for the release of information necessary to process my claim. I authorize payment for services by my insurance to the provider named. I understand and accept full financial responsibility for the charges on the above referenced patient.

Guarantor Signature Print Name Date

Address

Phone Number

ARKANSAS MAXILLOFACIAL SURGERY CENTER
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES
(You may refuse to Sign this Acknowledgement)

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name/ Patient or Legal Representative

_____
Signature (if Legal Representative, please state capacity)

Lack of Patient Acknowledgement:
Date Reason Staff Signature

Below is a list of persons that you give permission for our clinic to discuss and use the patient's protected health information, including condition and treatment plan, test results, prescriptions, X-ray:

Name:	Relationship to You	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that is my responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's healthcare information.

_____ _____
Patient Signature/Legal Representative Date

If legal Representative, explain the capacity:_____

5400 Highland Drive, Little Rock, AR. 72223 Ph: 501-225-8929 Fax: 501-225-0334
411 Office Park Drive, Bryant, AR. 72022 Ph: 501-943-3310 Fax: 501-943-0891

General Consent to Dental Treatment During COVID-19

Patient's Name: _____ Birthdate: _____ Chart #_____

Thank you for choosing our office for your dental needs. Our goal is to provide you with high quality dental care. The Arkansas Department of Health (ADOH) has recommended that dental facilities and healthcare providers may resume services that require minimal protective equipment on May 11, 2020. Because dental work often creates aerosols, it carries an added risk of spreading COVID-19. This form is being provided to you to identify potential risks of dental treatment during COVID-19. If you or a member of your household are experiencing symptoms of COVID-19 (e.g., fever, cough, shortness of breath), **please alert a member of our staff immediately**. We must be aware of such symptoms or any positive COVID-19 tests immediately to protect our dental office.

While all dental care has certain inherent risks and complications, patients face additional risks during the COVID-19 pandemic. These include, but are not limited to, increased risk of exposure to COVID-19. While we are taking all reasonable precautions to prevent the spread of COVID-19, it is impossible to eliminate that risk. Dentists and/or staff are exposed to multiple patients, who could be asymptomatic carriers of COVID-19. Complications of COVID-19 may include acute respiratory distress syndrome, irregular heart rate, cardiovascular shock, severe muscle pain, fatigue, heart damage or heart attack. The risk of complications is increased for individuals aged 65 and older, and individuals with compromised immune systems and/or chronic disease.

By signing this form, you acknowledge that in-person treatment for your dental condition presents increased risk of contracting COVID-19. You further acknowledge that for us to perform the treatment, we must be closer than the CDC recommended 6 ft. in proximity. You further agree that you will follow certain procedures as required by the ADOH, including but not limited to hand washing and wearing a surgical mask at certain times.

IF YOU EXPERIENCE ANY COVID-19 SYMPTOMS OR TEST POSITIVE FOR COVID-19 AFTER RECEIVING DENTAL TREATMENT, PLEASE CONTACT YOUR PRIMARY HEALTH CARE PROVIDER AND OUR DENTAL OFFICE IMMEDIATELY.

I give consent for myself/my child to receive dental treatment during the COVID-19 pandemic deemed necessary or recommended by the providers at this office.

This consent shall be considered in effect until rescinded or revoked.

_____ _____

(print your name) (relationship)

_____ _____

(Signature) (date)

ARKANSAS MAXILLOFACIAL SURGERY CENTER

RECEIPT OF PATIENT BILL OF RIGHTS

I have read and understand my Rights and Responsibilities as described in the Arkansas Maxillofacial Surgery Center *Rights of Patients* information.

_____

Patient Name

_____

Patient/ Legal Representative Signature (If legal representative, please state capacity)

_____

Date

5400 Highland Drive, Little Rock, AR. 72223 – Ph: 501-225-8929 Fax: 501-225-0334
411 Office Park Drive – Bryant, AR. 72202 – Ph: 501-943-3310 Fax: 501-943-0891

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