9601 Baptist Health Dr.
Suite 104
Little Rock, AR 72205
Ph: 501-224-0144
Fx: 501-224-0355

Dental Solutions OF LITTLE ROCK

16301 Chenal Parkway
Suite 200
Little Rock, AR 72223
Ph: 501-448-2944
Fx: 501-448-2796

Patient Personal Information

Title ______ Nickname ______ Birth Date ______ Age ______
Last, First ______ Marital Status ______ Sex ______
Address ______ Home # ______ Work # ______
City, State, Zip ______ Cell # ______ Drive Lic ______
E-Mail ______ Student ______ SSN ______
Would you like appt confirmation by email or text? ☐ Y ☐ N Do you have family members that are patients here? ☐ Y ☐ N
Referred By ______ If so, who? ______

Person responsible/Guarantor for paying bills

Title ______ Nickname ______ Birth Date ______ Age ______
Last, First ______ Marital Status ______ Sex ______
Address ______ Home # ______ Work # ______
City, State, Zip ______ Cell # ______ Drive Lic ______
E-Mail ______ SSN ______

Do you have Primary Dental Insurance? ☐ Yes ☐ No

Group No./ Name ______
Insurance Name ______
Phone # ______
Employer Name ______
Subscriber Last, First ______
Subscriber Address ______
City, State, Zip ______
Relationship to Patient ______ Birth Date ______
Subscriber ID ______

Do you have Secondary Insurance? ☐ Yes ☐ No

Group No./ Name ______
Insurance Name ______
Phone # ______
Employer Name ______
Subscriber Last, First ______
Subscriber Address ______
City, State, Zip ______
Relationship to Patient ______ Birth Date ______
Subscriber ID ______

Have you seen another DDS or Specialist this year? ☐ Y ☐ N

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Latex
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Other ______
- ☐ Y ☐ N Penicillin/Antibiotics
- ☐ Y ☐ N Sulfa

Check, if applicable

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Antibiotic for Dental Treatment
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Cancer / Tumor
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Dementia/Memory Loss
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Eating Disorder
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequent Dry Mouth/ Sjogren
- ☐ Y ☐ N GERD/Acid Reflux
- ☐ Y ☐ N Hepatitis A, B, or C
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney Disorders
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Osteoperosis
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Sleep Disorders
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

Heart/Cardiovascular

- ☐ Y ☐ N Atrial Fibrilliation (AFIB)
- ☐ Y ☐ N Blood Clotting
- ☐ Y ☐ N Blood Thinners/Asprin
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain / Angina
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N COPD
- ☐ Y ☐ N Damaged/Artificial Heart Valve
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Chest Pain / Angina
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Defect
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Surgery
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Irregular Heartbeat
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Stroke

Dental Questionnaire

Name of previous Dentist and their phone number ______________________

Date of your last cleaning ______________________

Last dental visit ______________________

Date of your last x-rays ______________________

Do your gums bleed while brushing or flossing? ______________________

Are your teeth sensitive to hot, cold or sweets? ______________________

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth? ______________________

Have you ever had burning of the tongue or cracking of the corners of your mouth? ______________________

Do you use tobacco in any form? If so, what type and how much? ______________________

How often do you drink alcoholic beverages? ______________________

Have you had any head, neck or jaw injuries? ______________________

Do you notice popping, clicking or soreness of the jaws? ______________________

Do you clench or grind your teeth? ______________________

Have you ever worn a mouthpiece or an appliance for TMJ, clenching or grinding? ______________________

Do you have difficulty in opening your mouth widely? ______________________

Have you ever had orthodontic treatment? ______________________

Do you wear dentures or partials? If Yes, how old are they? ______________________

Are you happy with your dentures/partials? ______________________

Are you having any specific problems with your teeth, gums, or mouth at this time? ______________________

Are you happy with your smile? ______________________

Do you have problems with teeth/fillings breaking? ______________________

Do you regularly use dental floss? ______________________

Have you ever been told you have Periodontal (Gum) Disease? ______________________

Do you have an unpleasant taste or odor in your mouth? ______________________

Have you noticed any loosening of your teeth? ______________________

Does food catch between your teeth? ______________________

Do you think you will lose your teeth in your lifetime? ______________________

Do you gag easily? ☐ Yes ☐ No

Would you like N2O (laughing gas) during dental treatment? ______________________

Have you been told you need to premedicate (take antibiotics) prior to dental or medical procedures? ______________________

Medical Questionnaire

Emergency Contact

Emergency contact name ______________________

Emergency contact phone ______________________

Emergency contact relationship to patient ______________________

Medical Questionnaire

Family Physician ______________________

Physician phone number ______________________

Please list any medical conditions ______________________

List any serious illness, operation, or hospitalization within the past 5 years. ______________________

List of Medications you are taking, including Over-The-Counter: ______________________

____

Have you ever taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ______________________

Do you snore? ☐ Yes ☐ No

Have you had a sleep study or been told you need a sleep study? ☐ Yes ☐ No

Do you use CPAP? ☐ Yes ☐ No

Have you been diagnosed with sleep apnea, but are intolerant to CPAP? ☐ Yes ☐ No

Women Only

Are you pregnant ? If Yes, what is your Due date ? ______________________

Are you currently nursing ? ______________________

Are you on hormone replacement therapy ? ______________________

Are you on birth control pills / fertility drugs ? ______________________

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ______________________

____

____

By signing below, I certify that all of the above information is true to the best of my knowledge.

______________________ ______________________

Patient / Guardian Signature **Date**

Building Better Relationships Through Financial Arrangements

Our goal is to build respectful relationships with our patients through a mutual understanding of our financial expectations.

The following is a statement of our financial agreement. We want you to be completely informed as to our expectations prior to any treatment. **PLEASE READ CAREFULLY AND SIGN/DATE THE BOTTOM.**

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment plans for the use of our patients:

1. Payment in full at the time of service
2. Care Credit
3. Use of your Visa, Mastercard, Discover or American Express cards
4. Short-term extended payments may be available upon request

*All treatment involving a laboratory procedure will require an appropriate down payment.

REGARDING EXTENDED PAYMENT ARRANGEMENTS – A credit history will be obtained prior to making any extended payment arrangements. By signing this form you give us permission to obtain a current credit report.

REGARDING INSURANCE – We will do our best to **ESTIMATE** the amount that your insurance company will pay. However, **the balance of your account is your responsibility regardless of what your insurance company pays.** We cannot be responsible for knowing the details of your dental plan. Therefore if your insurance does not pay for a procedure, regardless of the estimate previously given, you will be responsible for payment. Professional care is provided to you, our patient, and not to an insurance company. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. If your insurance company has not paid your account in full within 90 days from the date of service, the balance will be automatically transferred to your account.

REGARDING SECONDARY INSURANCE – We will be happy to file your secondary insurance. However, your payment plan will be based on your ESTIMATED PRIMARY INSURANCE ONLY and your secondary insurance will pay you, the subscriber.

APPOINTMENTS –We do make every effort to be on time for our patients, and ask that you extend the same courtesy to us. If you cannot keep an appointment, please notify us immediately. Unless cancelled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

Please remember you are responsible for timely payment of your account. Should you have a balance on your account, full payment is expected within 10 days of the statement date. A 12% APR Finance charge will apply to balances over 60 days, even if you have outstanding insurance. Should it become necessary to refer your account to an agency or attorney for collection, you will be responsible for all costs associated with the collection including attorney's fees, court costs or any fees associated with collecting the debt.

Thank you for understanding our agreement. Please let us know if you have any questions or concerns!
I have read the above Financial Agreement and I understand and agree to the above conditions.

____

Signature of patient or guardian date

I give permission for a past credit history to be obtained.

____

Signature of patient or guardian date

Dental Solutions of Little Rock

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT --- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice to Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign Consent. Our Notice provides a description of our treatment, payment activities, and health care 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 is available upon request. 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 Notice of 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 we may have.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Baptist Location - Telephone: (501) 224-0144 Fax: (501) 224-0355

Chenal Location - Telephone: (501) 448-2944 Fax: (501) 448-2796

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 that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continuing to treat you if you revoke this Consent.

Signature

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health and insurance information to carry out treatment, payment activities, and health care operations.

Signature:______________________ Date:______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:______________________

Relationship to Patient:______________________

Please list the following family members or persons, whom we may inform about your general dental condition and diagnosis, including treatment payment: ______________________

____

____

Revocation of Consent:

I revoke my Consent for your use and disclosure of my protected health and insurance information for treatment, payment activities, and health care operations.

I understand that the revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature:______________________ Date:______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include a completed Consent in the patient's hard chart

BROKEN APPOINTMENT POLICY

Mutual Respect:

At Dental Solutions we recognize just how busy life can be and we value your time. We know that schedules can change and we strive to do our best to stay on time. We respect your schedule and in return we ask that you please respect our schedule by keeping your appointments and doing your best to be on time. Missing an appointment or being late can disrupt many other patients and possibly prevent other patients from receiving their care. The following fees may be charged to your account if you should fail to show up for your scheduled appointment or fail to inform our office at least 24 hours prior to cancelling / changing your appointment. We understand that unavoidable scheduling conflicts can arise and we are more than happy to work with you when these situations occur.

No Show Fee:

Dental Solutions of Little Rock reserves the right to charge $75.00 to the account of a patient who cancels or fails to keep their appointment without notifying Dental Solutions of Little Rock within 24 hours of their scheduled appointment time. If a patient misses, without giving at least a 24 hour notice, two or more appointments within a 12 month period the patient may be required to prepay in full for any future treatments in order to reschedule.

Thank you for your understanding and respect regarding keeping your appointments with Dental Solutions of Little Rock. This simple courtesy will go a long way to help all our patients. Should you have any questions regarding this new policy please feel free to contact us at our Chenal location: (501) 448-2944 or our Baptist location: (501) 224-0144 or you may text us at 501-302-0000.

Respectfully,

Dental Solutions of Little Rock

Signature________________________________ **Date** ________________

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Little Rock, AR 72223
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Fx: 501-448-2796

How did you locate us?

We know that you had many other Dental offices to choose from so we want to thank you for selecting Dental Solutions of Little Rock. In order to better know our patients, please share with us how you loacated our office.

Personal Referral

So that we may show our appreciation, please share with us the name of the person that referred you.

____

Location / Convenience

Baptist Location __________

Chenal Location __________

Internet

Google Search __________

Website __________

Web Ratings __________

Testimonials __________

Other

Please Describe ______________________________________

Thank you for your time!