Advanced Dental Care
Committed to Excellence

KEYVAN KAR DDS

PROSTHODONTIST

WWW.ADVANCEDDENTALCAREOFALLEN.COM
Tel: 214-260-9911
950 W STACY RD, SUITE 150
ALLEN, TX 75013

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

WORK: X
DIRECT:
OTHER:
PAGER:
FAX:

E-Mail:

INSURANCE INFORMATION

Subscriber:
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

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PREVIOUS DENTIST INFORMATION

Dentist: ..... Telephone: .....

Clinic/Facility: .....

Address: .....

..... CITY ST ZIP CODE

Reason for changing: .....

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: ..... Treatment Type: .....

☐Y☐N Are you currently having dental discomfort? If yes, explain: .....
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: .....
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: .....
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

.....

The most important concerns regarding my dental treatment are:

.....

What factors are most important for your satisfaction with our office?

.....

Any additional concerns/comments?

.....

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

.....

☐Y☐N Any unusual speech habits? If yes, explain: .....
☐Y☐N Any lost teeth? If yes, list: .....
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

.....

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....

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☐Y☐N Any serious illnesses/surgeries?

☐Y☐N Use tobacco in any form? If Yes, Type:

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS

☐OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS

☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Kar of the dental benefits otherwise payable to me.

I hereby authorize Dr. Kar to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date: _____

Social Media Consent

I hereby authorize Advanced Dental Care to use photos of myself or my child on social media or their website.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date: _____

I hereby **DENY** Advanced Dental Care to use photos of myself or my child on social media or their website.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date: _____

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PRIVACY POLICY

In our efforts to comply with the Health Information Privacy Act, HIPAA, we need to be certain that we guard your medical and dental information to the best of our ability. Please read, initial, and date the following so that you will be informed of how we will use your information.

APPOINTMENT CONFIRMATION: By initialing the following, you are giving us permission to leave a message either at home or on your cell to confirm your appointments.

Initial:_____

REFERRING DOCTOR OR DOCTOR TO BE REFERRED TO: By initialing the following, you are allowing us to contact a referring doctor and discuss your treatment with their office or contact a doctor that we would like to refer you to and give them any information they may need in order to properly treat you.

Initial:_____

INSURANCE CLAIM PROCESSING: Dr. Kar does not accept insurance for payment of treatment. You, the patient, is responsible for payment of treatment at the time of service. We will however, fill out all necessary forms to send into your insurance provider to ensure prompt claim processing. By initialing the following, you are allowing us to send information to your insurance carrier for claim processing.

Initial:_____

DENTAL LAB WORK: By initialing the following, you are allowing us to transfer information to our dental technicians regarding treatment for you.

Initial:_____

PRIVACY POLICY: By initialing the following, you are accepting our privacy policy as written.

Initial:_____

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date: _____