

WWW.ADVANCEDDENTALCAREOFALLEN.COM

Tel: 214-260-9911

950 w stacy RD, Suite 150 ALLEN, TX 75013

Date:	Patient: LAST				PATIENT I	NFORMATION			
LAST	Last							IEW PATIENT	UPDATE
**IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: Parent/GUARDIAN NAME(S) Patient SSN:	*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) PARENT/GUARDIAN NAME(S) Patient Date of Birth: Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE PAGER: E-Mail: EMERGENCY INFORMATION In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address: ADDRESS LINE 2 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 EMPLOYMENT INFORMATION Employer: Address: ADDRESS LINE 1 BODRESS LINE 2 CITY ST ZIP CODE FAX: CITY ST ZIP CODE FAX: SUbscriber Date of Birth: Subscriber Employer: Patient Relationship to Subscriber: Subscriber Employer: Patient Relationship to Subscriber: Subscriber Employer: Patient Relationship to Subscriber: SUBSCRIBER SINE 2 CITY ST ZIP CODE FAX: TOLL-FREE: TOLL-	i ationt.	LAST		FIRST	MI	Preferred		TITLE
Patient Date of Birth:	PARENT/GUARDIAN NAME(S) Patient Date of Birth: Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP Code PAGER: FAX: Referral? Yes No Referred by: NAME RELATIONSHIP		□MALE	FEMALE	☐CHILD* ☐S	TUDENT**	SINGLE MARRIED	DIVORCED	□WIDOWED
Patient Date of Birth: Patient SSN: Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE PAGER: FAX: Referral? Yes No Referred by: E-Mail: REALTIONSHIP EMPLOYMENT INFORMATION Employer: Address: ADDRESS LINE 2 CITY ST ZIP CODE PAGER: FAX: Tel: BADDRESS LINE 2 EMPLOYMENT INFORMATION Employer: Address: ADDRESS LINE 2 ADDRESS LINE 3 ADDRESS LINE 3 ADDRESS LINE 4 ADDRESS LINE 5 ADDRESS LINE 5 ADDRESS LINE 6 ADDRESS LINE 6 ADDRESS LINE 7 ADDRESS LINE 8 ADDRESS LINE 8 ADDRESS LINE 9	Patient Date of Birth: Patient SN: Address: ADDRESS LINE 2 CITY ST ZIP CODE PAGER: FAX: Referral? Yes No Referred by:	*IF CHILD, F	PROVIDE PAREN	T/GUARDIAN NAI	ME(S) BELOW:	**IF STUDENT, PLEA	ASE COMPLETE:	FULL-TIME	PART-TIME
Address: ADDRESS LINE 2 ADDRESS LINE 2 CITY ST ZIP CODE PAGER: FAX: E-Mail: Referral?	Address: ADDRESS LINE 1 ADDRESS LINE 2 CTY ST ZIP CODE PAGER: PAGER: FAX: Referral? Yes No Referred by: CHECKER PAGER: FAX: PAGER: Tel: PAGER: PAGER: ADDRESS LINE 1 WORK: X DIRECT: OTHER: PAGER: PAGER:	PARENT/0	Guardian Name(s)					
ADDRESS LINE 1	ADDRESS LINE 2 ADDRESS LINE 2 CITY ST ZIP CODE PAGER: 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 EMPLOYMENT INFORMATION Employer: Occupation: Address: ADDRESS LINE 1 ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE FAX: CITY ST ZIP CODE FAX: UNSURANCE INFORMATION Subscriber: LAST FIRST MI PREFERRED TITLE Subscriber Date of Birth: Subscriber SSN: Subscriber Palate of Birth: Subscriber SSN: Subscriber Relationship to Subscriber: Self Spouse Child Other PRIMARY INSURANCE CARRIER: Group/Policy No: Address: TolFREE: FAX: SECONDARY INSURANCE CARRIER: Group/Policy No: ID No: Address: Tel: TolFREE: Group/Policy No: Address: Tel: TolFREE: Group/Policy No: Address: Tel: TolFREE: To		te of Birth:			Patient SSN:			
ADDRESS LINE 2 CELL: CEL	ADDRESS LINE 2 CELL: CITY ST ZIP CODE PAGER: E-Mail: Referral?	Address:	ADDRESS I INE 1						
ADDRESS LINE 2	ADDRESS LINE 2 CITY ST ZIP CODE PAGER: F-Mail: Referral?		ADDRESS LINE I				HOME:		
City ST ZiP Code PAGER: FAX:	CITY ST ZIP Code PAGER: FAX:		Address Line 2						
E-Mail: FAX:	E-Mail: FAX: Referral? Yes No Referred by:								
Referral?	Referral?		CITY		ST	ZIP CODE	Pager:		
EMERGENCY INFORMATION In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address: Tel:	EMERGENCY INFORMATION In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address: Tel: Tel:	E-Mail:					Fax:		
In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address: Tel:	In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address: Tel:		Referral?	∐Yes	Referred by:				
address: NAME RELATIONSHIP EMPLOYMENT INFORMATION Employer: Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE FAX: E-Mail: INSURANCE INFORMATION Subscriber: Subscriber Date of Birth: Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: Tel: Tel: Tel: Tel: Tol. FREE: Tel: Tol. FREE: Tel: Tol. FREE:	address: NAME RELATIONSHIP								
NAME RELATIONSHIP	EMPLOYMENT INFORMATION		emergency, pl	ease provide in	formation for the ne	arest relative or desi	ignated contact pe	erson not at	the patient's
EMPLOYMENT INFORMATION	EMPLOYMENT INFORMATION Employer:	NAME			DELATIONS		Tel:		
Employer: Occupation: Address: ADDRESS LINE 1 ADDRESS LINE 2 ADDRESS LINE 2 CITY ST ZIP CODE 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.: Address: Toll_EBEE:	Employer: Occupation: Address: ADDRESS LINE 1 ADDRESS LINE 2 ADDRES LINE 2	INAME							
Address: ADDRESS LINE 1 ADDRESS LINE 2 OTHER: PAGER: CITY ST ZIP CODE FAX: E-Mail: INSURANCE INFORMATION Subscriber: LAST FIRST MI PREFERRED TITLE Subscriber Date of Birth: Subscriber Employer: Patient Relationship to Subscriber: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: ID No.: TOLLEBEE:	Address: Address Line 1	Chamles (em							
ADDRESS LINE 1 ADDRESS LINE 2 ADDRESS LINE 2 OTHER: PAGER: PAGER: FAX: E-Mail: INSURANCE INFORMATION Subscriber: LAST FIRST MI PREFERED TITLE Subscriber Date of Birth: Subscriber Employer: Patient Relationship to Subscriber: PAGER: SUBSCRIBER: Subscriber SN: Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: Tel: Tol.: FIRST Direction Tol.: FIRST Direction Tol.: Tol.: FIRST Direction Tol.:	ADDRESS LINE 1 ADDRESS LINE 2 ADDRESS LINE 2 CITY ST ZIP CODE 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.: Address: SECONDARY INSURANCE CARRIER: Group/Policy No.: SECONDARY INSURANCE CARRIER: Group/Policy No.: Address: Tel: Toll-FREE: FAX: Tel: Toll-FREE: Group/Policy No.: Address: Tel: Toll-FREE:					Occupation:			
ADDRESS LINE 2 OTHER: PAGER: CITY ST ZIP CODE 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.: Address: TEL: TOLLEBEE:	ADDRESS LINE 2 ADDRESS LINE 2 CITY ST ZIP CODE 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.: Address: ID No.: SECONDARY INSURANCE CARRIER: Group/Policy No.: SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: ID No.: Address: Tel: Group/Policy No.: Address: ID No.: TEL: TOLL-FREE: FAX: TEL: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE:	Addiess.	Address Line	1			 Work:		X
E-Mail: INSURANCE INFORMATION FAX: FAX: FAX: FAX: FAX: FAX: FAX: FAX: FIRST FIRST MI PREFERRED TITLE FAX: FIRST Subscriber SSN: Subscriber Employer: FAX: FIRST FIR	CITY ST ZIP CODE 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: Tel: Toll-FREE: FAX: SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: Tel: Toll-FREE: FAX: Tel: Toll-FREE: Toll-FREE: Toll-FREE: Toll-FREE: Toll-FREE: Toll-FREE:								
E-Mail: ST ZIP Code FAX: FAX:	City ST ZIP Code FAX:		Address Line 2	2			OTHER:		
E-Mail: INSURANCE INFORMATION	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: TEL: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE:						DACED:		
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: Toll_FEREE:	INSURANCE INFORMATION Subscriber: LAST FIRST MI PREFERRED TITLE Subscriber Date of Birth: Subscriber SSN: Subscriber Employer: Patient Relationship to Subscriber: SPOUSE CHILD OTHER PRIMARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: FAX: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: FAX: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE:		CITY		ST	ZIP CODE	Fax:		
Subscriber: LAST FIRST MI PREFERRED TITLE	Subscriber: LAST FIRST MII PREFERRED TITLE Subscriber Date of Birth: Subscriber SSN: Subscriber Employer: Patient Relationship to Subscriber: SPOUSE CHILD OTHER PRIMARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: FAX: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE:	E-Mail:							
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: Toll-FEREE:	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: TEL: TOLL-FREE: FAX: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE:				INSURANCE	INFORMATION			
Subscriber Date of Birth: Subscriber SSN: Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: ID No.: Toll_ERRE:	Subscriber Date of Birth: Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: TEL: TOLL-FREE: FAX: TOUL-FREE: FAX: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE: TOUL-FREE:	Subscriber	··						
Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: Toll-FREE:	Subscriber Employer: Patient Relationship to Subscriber: PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: CITY ST ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: FAX: TOLL-FREE: FAX: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE: TOLL-FREE:				FIRST		Preferred		TITLE
Patient Relationship to Subscriber: Self Spouse Child Other PRIMARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: Tel:	Patient Relationship to Subscriber: Self					Subscriber SSN	:		
PRIMARY INSURANCE CARRIER: Group/Policy No.: Address: Tel: Toll-eres:	PRIMARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: FAX: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: ID No.: Address: TEL: TOLL-FREE: TOLL-FREE:								
Group/Policy No.: ID No.: Address: TEL:	Group/Policy No.:				_SELF	.D ∐OTHER			
Address: Tel:	Address: TEL: TOLL-FREE: FAX: CITY ST ZIP CODE SECONDARY INSURANCE CARRIER: Group/Policy No.: Address: ID No.: TEL: TOLL-FREE: TOLL-FREE:					15 A I			
	TOLL-FREE: FAX: FAX: FAX:						T⊏i·		
I OLL-I INLL.	FAX:	7 (441000)					TOLL_EBEE:		
FAY	ST ZIP CODE						ΕΛΥ·		
CITY ST ZIP CODE	Group/Policy No.: ID No.: Address: Tel: Toll-Free:	0			ST	ZIP CODE			
	Address: Tel: Toll-free:			E CARRIER:					
	TOLL-FREE:		Су INO			וט ווט.:	T=:·		
		Addiess.							
							FAX:		



WWW.ADVANCEDDENTALCAREOFALLEN.COM

Tel: 214-260-9911

950 w stacy RD, Suite 150 ALLEN, TX 75013

	PREVIOUS DENTIST INFORMATION				
Dentist: Clinic/Facility: Address:	Telephone:				
Reason for ch	CITY ST ZIP CODE anging:				
	DENTAL HISTORY				
ORAL HEALTH: Date of Last D	EXCELLENT GOOD FAIR POOR Dental Visit: Treatment Type:				
□Y□N A □Y□N A □Y□N A □Y□N A □Y□N A □Y□N A □Y□N B □Y□N	Are you currently having dental discomfort? If yes, explain: Any unhappy/unpleasant dental experiences? If yes, explain: Any injuries to mouth/teeth/head? If yes, explain: Any missing teeth other than wisdom teeth or orthodontic extractions? Have missing teeth been replaced? Orthodontic appliances now or in the past? Gums bleed when brushing or flossing? Concerned about gum disease? History of gum disease? Any concerns about the appearance of your teeth? Ones it hurt to bite or chew? Ones you clench or grind your teeth? If so, do you wear a night guard or splint? One you want to become a regular continuing care patient in our practice? Ones you want your mouth properly restored and pain free? Ones any type of dental treatment make you nervous? If yes, please explain below:				
The most important concerns regarding my dental treatment are:					
What factors a	are most important for your satisfaction with our office?				
Any additional	concerns/comments?				
Y N A	PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS: Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.) Any unusual speech habits? If yes, explain: Any lost teeth? If yes, list: Does the patient receive assistance with brushing and flossing? If yes, how often?				

MEDICAL HISTORY GENERAL HEALTH: DEXCELLENT GOOD FAIR POOR Under a physician's care now? \square Y \square N Any hospitalization in the past 5 years? \square Y \square N



WWW.ADVANCEDDENTALCAREOFALLEN.COM

Tel: 214-260-9911

ntalCare prosthodontist 950 W STACY RD, SUITE 150 ALLEN, TX 75013 Any serious illnesses/surgeries? \square Y \square N \square Y \square N Use tobacco in any form? If Yes, Type: \square Y \square N Is pre-medication required before dental visits due to heart condition or artificial joint? \square Y \square N Taking any prescription or daily OTC medications/drugs? If yes, list details in the Medication Section. FEMALE PATIENTS: ☐Y☐N Currently nursing? YN 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? \(\subseteq Y \subseteq N \) If ves. please describe: Is there anything important about your medical condition we have not asked? \(\subseteq Y \subseteq N \) If yes, please describe: ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE PSYCHIATRIC TREATMENT ACID REFLUX □ BULIMIA HEARING PROBLEMS □ADHD CANCER/MALIGNANCY HEART ATTACK RADIATION/CHEMO □AIDS/HIV CEREBRAL PALSY THEART DISEASE RESPIRATORY DISEASE □ANEMIA CHEMICAL DEPENDENCY HEART MURMUR RHEUMATIC FEVER ANOREXIA CHICKEN POX THEPATITIS SINUS PROBLEMS ANXIETY CONVULSIONS HIGH BLOOD PRESSURE STROKE ARTIFICIAL HEART VALVE DEPRESSION KIDNEY DISEASE THYROID CONDITION ARTIFICIAL JOINTS TUBERCULOSIS DIABETES LIVER PROBLEMS ARTHRITIS DIZZINESS/FAINTING MITRAL VALVE PROLAPSE □ULCERS □ASTHMA □EPILEPSY/SEIZURES MONONUCLEOSIS TVENEREAL 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): ASPIRIN CODEINE SLEEPING PILLS None LACTOSE INTOLERANCE 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 BLOOD PRESSURE MEDICATIONS ANTIBIOTICS/SULFA DRUGS ANTIHISTAMINES/ALLERGY DAILY ASPIRIN 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**

PATIENT REGISTRATION & HISTORY 3/5



WWW.ADVANCEDDENTALCAREOFALLEN.COM Tel: 214-260-9911

950 w stacy RD, Suite 150

PROSTHODONTIST ALLEN, TX 75013

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 ha	ave 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:					

PATIENT REGISTRATION & HISTORY



Signature:

KEYVAN KAR DDS

WWW.ADVANCEDDENTALCAREOFALLEN.COM

Tel: 214-260-9911

950 w stacy RD, Suite 150 ALLEN, TX 75013

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.

PATIENT REGISTRATION & HISTORY 5/5

Date: