Implants | Wisdom teeth | Cosmetic & General Dentistry

12700 Midway Rd, Ste 104, Dallas, TX-75244: PH: (214) 702 0163

Patient Information Sheet

DATE
CHART #

FIRST NAME	MI	LAST NAME	DOB	SEX M F
SSN	ID TYPE (SELECT ONE) DRIVER'S LICENSE STATE ID FEDERAL ID PASSPORT OTHER	DRIVER'S LICENSE/ID #	ST	
E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY
HOME ADDRESS	APT	CITY	ST	ZIP
EMPLOYER	POSITION	HOW LONG? YEAR MONTH		
EMPLOYER ADDRESS	CITY	ST	ZIP	

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	DOB	SEX M F	RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT
SSN	ID TYPE (SELECT ONE) DRIVER'S LICENSE STATE ID FEDERAL ID PASSPORT OTHER	DRIVER'S LICENSE/ID #	ST		
E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY	
HOME ADDRESS	APT	CITY	ST	ZIP	
EMPLOYER	POSITION	HOW LONG? YEAR MONTH			
EMPLOYER ADDRESS	CITY	ST	ZIP		

MEDICAL CONTACTS: CURRENT DENTIST

DENTIST NAME	PHONE NUMBER		
ADDRESS	CITY	ST	ZIP

EMERGENCY CONTACTS

CONTACT #1 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	
E-MAIL	HOME PHONE	CELL	WORK PHONE
CONTACT #2 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	
E-MAIL	HOME PHONE	CELL	WORK PHONE

PRIMARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME		
DOB	SEX M F	INSURED'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT	
HOME ADDRESS	APT		
CITY	ST	ZIP	INSURED'S SSN
EMPLOYER	EMPLOYER'S PHONE NUMBER		
INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER		
GROUP #	POLICY #		
POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER		

SECONDARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME		
DOB	SEX M F	INSURED'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT	
HOME ADDRESS	APT		
CITY	ST	ZIP	INSURED'S SSN
EMPLOYER	EMPLOYER'S PHONE NUMBER		
INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER		
GROUP #	POLICY #		
POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER		

INITIALS OF PATIENT	INITIALS OF RESPONSIBLE PARTY

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_______ INITIALS **Financial Responsibility:** I understand that payments for services should be made when due, and if any payment is not made timely, I may be subject to late fees. I further understand that if I have authorized debits to my account and should a debit not be honored by my bank, I will incur a service charge for each such dishonored debit. I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

_______ INITIALS **Information Verification:** The information provided herein is true and complete to the best of my knowledge. I authorize A & K Dental PLLC ("Prestige Dental"), or anyone acting on his behalf, to obtain, review and/or share with his designated agents, or any assignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to Prestige Dental or any assignee of my account. I acknowledge that Prestige Dental may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

_______ INITIALS **Prior Express Consent for Calls/Texts/Email:** By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that Prestige Dental and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with Prestige Dental, or for other informational purposes related to my account or treatment ("Communication"). I also agree that Prestige Dental and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. Prestige Dental will not charge for a Communication, but my service provider may. I agree that Prestige Dental may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_______ INITIALS **Broken Appointment Fee:** I understand that it is important that I keep my scheduled appointments and if I miss an appointment without prior notification, I may be subject to a broken appointment fee.

Prestige Dental will be using electronic medical records, including your photograph, to maintain your health care information. Prestige Dental is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.

You may, at any time, withdraw this consent with written notice to Prestige Dental.

_______ INITIALS **Yes.** I agree to have my photograph taken and stored in Prestige Dental's electronic medical records system. I understand that by checking "Yes" and signing below, I am giving Prestige Dental permission to take and use my photograph in its electronic medical records system for identification purposes.

_______ INITIALS **No.** I do not wish to have my photograph taken and stored in Prestige Dental's electronic medical records system.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

_______________________ SIGNATURE OF PATIENT _______________ DATE

_______________________ SIGNATURE OF RESPONSIBLE PARTY _______________________ RELATIONSHIP TO PATIENT _______________ DATE

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