BEE CENTER FOR DENTISTRY | ELIZABETH SHELTON, DDS

902 N. Saint Mary's St. | Beeville, TX 78102 | (361) 358-3384 | www.beecenterfordentistry.com

PATIENT REGISTRATION

Last Name____ First ____________________________________ MI ________

Preferred Name______________________________________ Birth Date _____/ _____/ ________ Age _____ Sex M / F

Social Security # ________/ ________/ ________ Marital Status: Married / Single / Widow

Mailing Address ____

City ____ State ______________________ Zip _________________

Home Phone: (_____) ______- _______ Work Phone: (_____) ______- _______ Cell: (_____) ______- _______

E-Mail ____ May we text/e-mail messages to you? _____________

Employer ____ Occupation _____________________________

Whom may we thank for referring you to our practice: ____

Name of Preferred Pharmacy: ________________________________ Pharmacy Phone #: _____________________________

ACCOUNT INFORMATION

Person Responsible for Account (If different than patient):

Last Name ___________________________________ First ________________________________ MI ________

Relationship to Patient _________________________ Birth Date _____/ _____/ _____ Age ________Sex M / F _

Home Address _______________________________________ City____________________State ________Zip___________

Home Phone: (____) _____- _______ Work Phone: (____) ______- _______ Cell: (____) ______- _______

Social Security # ________/ ________/ ________

Employer ____ Occupation _____________________________

Employer's Address _____________________________________ Employers Phone #: ______________________

DENTAL INSURANCE INFORMATION

PLEASE BRING YOUR DENTAL INSURANCE CARD TO YOUR APPOINTMENT

Insurance Company ____ Phone # (_____) _______- _______

Insured Name: ____ Self / Spouse / Parent

Insured SS# or ID # ____ Insured DOB ______/ ______/______

Employer Group Name ____ Group # ____________________

EMERGENCY CONTACT INFORMATION

Contact #1 Name :____ Phone # (______) ________- _______

Relationship to Patient: __________________________________

Contact #2 Name :____ Phone # (______) ________- _______

Relationship to Patient: __________________________________

BEE CENTER FOR DENTISTRY | ELIZABETH SHELTON, DDS

902 N. Saint Mary's St. | Beeville, TX 78102 | (361) 358-3384 | www.beecenterfordentistry.com

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering ALL of the following questions

Question	Yes/No	If Yes	
Are you under a physician's care now? If yes, please list condition, Dr's name and contact number	○ Yes ○ No	If Yes :	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If Yes:	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If Yes:	
Are you taking any medication, pills or drugs?	○ Yes ○ No	If Yes:	
Do you take, or have you taken Phen-Fen or Redux?	○ Yes ○ No	If Yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If Yes:	
Are you on a special diet?	○ Yes ○ No	If Yes:	
Do you use tobacco?	○ Yes ○ No	If Yes:	
Ever been diagnosed with SLEEP APNEA?	○ Yes ○ No	If Yes:	
Do you use a C-PAP or BI-PAP MACHINE?	○ Yes ○ No	If Yes:	
Do you SNORE?	○ Yes ○ No	If Yes:	
Do you use any controlled substances?	○ Yes ○ No	If Yes:	
			Women are you: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other

Do you have a history of:

Condition	Yes/No
A.I.D.S/HIV Positive	☐ ☐
Alcoholism	☐ ☐
Allergies	☐ ☐
Anemia	☐ ☐
Arthritis	☐ ☐
Asthma	☐ ☐
Blood Disease	☐ ☐
Bone Disease	☐ ☐
Cancer	☐ ☐
Chemical Dependency	☐
Chest Pain	☐
Circulatory Problems	☐ ☐
Convulsions/Seizures	☐ ☐
Diabetes	☐ ☐
Excessive Bleeding	☐ ☐
Epilepsy	☐ ☐
Glaucoma	☐ ☐
Hay fever	☐ ☐
Head injuries	☐ ☐

Condition	Yes/No
Hearing Impaired	☐ ☐
Heart Disease	☐ ☐
Heart Valve, Murmur	☐ ☐
Hepatitis/Liver Disease	☐ ☐
Type(s) ___________	
Hepatitis Carrier	☐ ☐
High Blood Pressure	☐ ☐
Hip or Joint replacement	☐ ☐
HPV	☐ ☐
Jaundice	☐ ☐
Kidney Disease	☐ ☐
Kidney Dialysis	☐ ☐
Latex Sensitivity	☐ ☐
Lupus	☐ ☐
Low Blood Pressure	☐ ☐
Malignancies	☐ ☐
Mitral Valve Prolapse	☐ ☐
Neck & Back Problems	☐ ☐

Condition	Yes/No
Nervous Problems/Disorders	☐ ☐
Pacemaker	☐ ☐
Prosthetic Joints	☐ ☐
Psychiatric Care	☐ ☐
Radiation Treatment	☐ ☐
Respiratory Problems/Disorders	☐ ☐
Rheumatic Fever	☐ ☐
Rheumatism	☐ ☐
Scarlet Fever	☐ ☐
Seizures/Fainting spells	☐ ☐
Sinus Problems	☐ ☐
Stomach Ulcers	☐ ☐
Stroke	☐ ☐
Thyroid Disease	☐ ☐
Tuberculosis	☐ ☐
Tumors or growth	☐ ☐
Ulcers	☐ ☐
Venereal Disease	☐ ☐

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_________________________________ Date: _____________________

BEE CENTER FOR DENTISTRY | ELIZABETH SHELTON, DDS

902 N. Saint Mary's St. | Beeville, TX 78102 | (361) 358-3384 | www.beecenterfordentistry.com

FINANCIAL POLICY

□ I understand that all payments are due at the time that services are rendered.
□ Our office accepts cash, MC, VISA Discover and American Express
□ Convenient Monthly Payment Options from Care Credit Healthcare Credit Card (Subject to credit approval)

- Allows you to pay over time, No annual fees or pre-payment penalties, No interest if paid in full within 6 or 12 months special financing options

□ 50% payment of your estimated out of pocket expense is required to secure your treatment reservation.
□ We charge $32.48 for returned checks.

INSURANCE POLICY

Dental insurance is not meant to be a pay-all, but an aid towards your dental care. There will almost always be some out-of-pocket expense that you will be expected to pay at the time of service. Insurance companies do not guarantee payment on claims and reserve the right to make payments based on their estimation of usual and customary rates. Your particular policy may base its reimbursement on a fee schedule that is lower than our office schedule.

□ I understand and agree that this dental office does not represent my dental insurance company and this office cannot make any representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by this office. It is a contract between your employer and the insurance company.
□ As a courtesy, our office will file a claim to your insurance provider if current and correct information is provided. You will be expected to pay your deductible and co-payment at the time of service, and we will file with the insurance company for available benefits.
□ If your insurance company denies, makes less than full payment, or takes more than 60 days to remit payment, you are responsible for the balance at that time.
□ We do our very best to calculate the probable amounts on insurance reimbursement with the information provided by you and your carrier, however, all figures quoted are purely estimates and are not intended to be represented as definite. We cannot be responsible for deficiencies or problems in your individual plans.

APPOINTMENT POLICY

All patients are seen by appointment only.
Office hours are Monday through Friday 8:30 - 5:00 (we close daily for lunch from 12:00–1:00)

□ Your appointment is reserved exclusively for you. If you need to reschedule your appointment, please verbally notify our office at least 48 business hours in advance.
□ We do not accept changes to the schedule on our voicemail system. This will allow another patient to be seen in your absence.
□ As a courtesy to you, all appointments will receive a 2 week early reminder from our office. At that time, we ask that you confirm the appointment, and update our office of any changes in your contact information, and/ insurance information.
□ A fee of $35 is charged for patients who miss their first appointment without 48-hour notice. $45 will be charged for the second missed appointment.
□ If a patient has three (3) last-minute cancellations or missed appointments; we reserve the right to terminate the patient/doctor relationship.

CONSENT

□ To the best of my knowledge, all the questions on this form have been accurately answered.
□ I give the dentist permission to use my reviews, photographs and/or videos for educational and promotional purposes.
□ I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
□ I authorize the release of any information concerning my (or my child's) health care, medical history, advice and treatment to another dentist of if applicable, an insurance company.

Signature of Patient, Parent or Guardian **Date**

Doctor Signature **Date**

BEE CENTER FOR DENTISTRY | ELIZABETH SHELTON, DDS
902 N. Saint Mary's St. | Beeville, TX 78102 | (361) 358-3384 | www.beecenterfordentistry.com

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.

I also authorize Bee Center for Dentistry to discuss my medical and dental care with the following individual(s) listed below. If there are any limitations on what we may discuss with these individuals, it must be received in writing and will be added to your file. This will remain in force unless revoked in writing.

Name	**Relationship**
____	________________________
____	________________________
____	________________________

____ ________________________

Patient Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify in the box below):