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: _____

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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

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:	
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, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Rheumatism	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Shingles	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments or concerns to share with the Doctor:

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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**

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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):

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Notice of Privacy Practices

NOTICE DESCRIBING HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA. Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official:
Terry Gutierrez
902 North St. Mary's Street
Beeville, Texas 78102
Office (361) 358-3384
Fax (361) 358-5199