Creating beautiful, healthy smiles for a lifetime

Beth A. Shelton, DMD William L. Hood, DDS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Creative Smiles make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK *ONLY* ONE

- ☐ I have read or had explained to me Creative Smiles Notice of Privacy Practice and **agree to continue treatment with Creative Smiles under said terms.** (A copy is posted at the front desk, or we can provide you with a personal copy.)

- ☐ **I was given** the opportunity to read Creative Smiles Notice of Privacy Practice and **declined but wish to continue my treatment with Creative Smiles under said terms.**

- ☐ I have read or had explained to me Creative Smiles Notice of Privacy Practice and ***do not wish to continue my treatment*** with Creative Smiles under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as _____

_____ _____

Patient Signature Date

If patient is a **minor** or you are patients **power of attorney** (must provide documentation), please sign as a personal representative of the patient; please indicate your relationship.

_____ _____

Representative Relationship to Patient

According to federal law, this office is not allowed to release any information on you without your consent. Please list anyone we may speak to on your behalf.

NAME PHONE NUMBER RELATIONSHIP TO PATIENT

_____

_____

_____

_____

_____

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care; therefor financial responsibilities on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare patients insurance forms, assist in making collections from insurance companies and will credit any such collections to the patient's account. **However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of when said services are rendered or with five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or our assignee, to telephone me at home or at my work to discuss matters related to this form.

I grant my permission to the staff of Dr. Beth Shelton to contact my physician for any reason which they deem necessary or pertinent to my dental care.

I have read the above conditions of treatment and payment and agree to their content.

_____ date: _____ relationship to patient _____
Signature of patient, parent or guardian

Patient Registration

Date_____

Dentistry for the Family
Beth Shelton, DMD, PA
William Hood, DDS
415 N. Gloster Street
Tupelo, MS 38804

PATIENT INFORMATION

Patient Name_____ DOB___/___/_____ _____ ☐M ☐F
First M.I. Last Age

Address_____ City, State, Zip_____

Email_____ Employer_____

Home Phone # (___)_____ Work # (___)_____ ext.____ Cell # (____)_____

Social Security Number _____-_____-_____ U.S. Citizen Yes No Driver's license #_____ State_____

Marital Status ☐ Single ☐ Married ☐ Divorced

Person to contact if unable to reach you directly

Name of Friend or Relative _____ _____
(not living with you) First M.I. Last Relationship

Address:_____ City, State, Zip_____

Phone (_____)_____

List family members who are current patients, if any: _____

From whom or how did you hear about our office? _____

PERSON RESPONSIBLE FOR ACCOUNT

Please complete this section if other than the above person.

Patient Name_____ DOB___/___/_____ _____ ☐M ☐F
First M.I. Last Age

Please check one: ☐Self ☐Father ☐Mother ☐Wife ☐Husband ☐Guardian

Address_____ City, State, Zip_____

Employer_____ Social Security Number _____-_____-_____

Home Phone # (___)_____ Work # (___)_____ ext.____ Cell #(____)_____

METHOD OF PAYMENT

☐ I do not have dental insurance and I agree to pay for any and all treatment IN FULL on the day of service.

☐ I have dental insurance and am responsible for paying my estimated portion on the day of services are rendered.

AUTHORIZATION ALL PATIENTS OR GUARDIANS MUST SIGN

- I authorize the dentist to peform diagnostic procedures and treatment, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary for proper dental care.
- I authorize the use of a third party company to verify my employer's insurance company and insurance plan.
- I agree that I am responsible for paying my balance on the day services are rendered.
- I am responsible for all legal and business costs related to non-payment of accounts including collection costs.

X_____ _____
Patient or Guardian's Signature Date

Medical History

Beth Shelton, DMD, PA
William Hood, DDS

Patient Name _____

Name of Physician _____ Phone Number:_____

Date/purpose of last visit _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

_____

Please list any other medications taken in the last 2 years:_____

Are you on a special diet? ☐ Yes ☐ No

Do you or have you ever used tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Are you currently taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

_____

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Local Anesthetics ☐ Erythromycin ☐ Tetracycline ☐ Fluoride
☐ Metals (Gold, Stainless steel) ☐ Other If yes, please explain:_____

Have you (or your dependent child) ever had any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Digestive Disorders (i.e. gastric reflux)	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Alcohol/Drug Dependency	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Anemia or other blood disorder	☐ Yes ☐ No	Epilepsy/convulsions (seizures)	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Any lumps or swelling in the mouth	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No	Osteoporosis/osteopenia (taking bisphosphonates)	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Prolonged bleeding due to a slight cut	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Attack/failure	☐ Yes ☐ No	Renal dialysis	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Heart problems/disease	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Breathing or sleeping problems (i.e. snoring, sinus)	☐ Yes ☐ No	Heart pacemaker	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	Sinus trouble	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	High Blood pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cold sores/Fever blisters	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No	Thyroid or parathyroid disease	☐ Yes ☐ No
Congenital heart disorder	☐ Yes ☐ No	Hives, rash, hay fever	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cortisone medication	☐ Yes ☐ No	HPV(Human Papilioma Virus)	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tumor, abnormal growth	☐ Yes ☐ No
		Kidney disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No

Please list any serious illness not listed above, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's signature_____ Date _____

Doctor's signature_____ Date _____

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Dental History

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist_____ How long have you been a patient? _____Months/Years
Date of most recent dental exam_____/_____/_____ Date of most recent X-Rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐ Yes ☐ No
Is there anything about the appearance of your teeth that you would like to change?	☐ Yes ☐ No
Do you/would you have any problems chewing gum?	☐ Yes ☐ No
Do you/would you have any problems chewing bagels or other hard foods?	☐ Yes ☐ No
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐ Yes ☐ No
Are your teeth crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐ Yes ☐ No
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐ Yes ☐ No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐ Yes ☐ No
Do you have tension headaches or sore teeth?	☐ Yes ☐ No
Do you wear or have you ever worn a bite appliance?	☐ Yes ☐ No
Have you ever had trouble getting numb or reactions to local anesthetic?	☐ Yes ☐ No

Please rate, in order of value, what is most important to you in your dental care:

(The most important will be #1.)

____ Preventive care

____ Only what is necessary at the time: Cost is important

____ Comprehensive, quality care

____ The look of my smile

____ Other _____

Please rate, as above, what is most important to you in your relationship with a dentist:

____ Show me what he/she is doing or planning to do so I can clearly see what is happening.

____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.

____ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have regarding dental treatment. (10 being the most fearful, 1 being the least amount of fear.)

1 2 3 4 5 6 7 8 9 10

Patient's signature_____ Date_____

Doctor's signature_____ Date_____