Shelton Dental
8522 Broadway
Suite 201
San Antonio TX 78217
(210)590-7878
info@drshelton.com
www.drshelton.com

Patient Information

Chart #. ____________
FOR OFFICE USE ONLY

Patient Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Title: ________ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ SS #. ____________ Prev. Visit: ____________

Email Address: ____________ Best time to call: ____________

Phone: ____________ (Home) ____________ (Work) ____ (Ext) ____________ (Mobile) ____________ (Fax) ____________ (Other)

Address: ____________ ____________
____________ (City) ____ (State) ____________ (Zip Code)

Mailing (if different):

Address: ____________ ____________
____________ (City) ____ (State) ____________ (Zip Code)

Driver's License #:
____

Preferred method of contact?

☐ email ☐ text message ☐ phone (cell) ☐ phone (work) ☐ phone (home)

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Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______ Phone: ______

Address: ______ ______

______ City ______ State ______ Zip Code

Occupation:

______

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ SS #. ______ Driver's License #: ______

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______

______ City ______ State ______ Zip Code

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Emergency Information

If an emergecy occurs, name and phone # of who we should contact? Relationship?

Additional contact name and phone # of the nearest relative not living with you:

Referral Information

Whom may we thank for referring you to our practice?

☐ Patient ☐ Family Member ☐ Doctor ☐ Other

Or did you locate us from a different source?

☐ Radio ☐ Web Site ☐ Phone Book ☐ Location ☐ Other

Name of person, office, or other source referring you to our practice:

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Consent for Services

I consent and authorize the dentist, hygienist, or assistants of Shelton Dental to complete any necessary radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. I also consent to the following:

During the course of treatment, I may undergo procedures in any of the following areas of dentistry including periodontics (gum treatment), oral surgery, endodontics (root canals), fixed and/or removable prosthodontics (crowns, bridges and dentures), restorative dentistry and orthodontics. Before any of the above is completed I will have been given a treatment plan & given my permission to proceed with treatment.

I will provide a complete and thorough medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I will also inform Shelton Dental of any changes in my health status or any changes in medications at my next appointment.

I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

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

Relationship to Patient:

Response Date: