Bee Family Dentistry

8647 Wurzbach Rd #A
San Antonio, TX 78240

O: (210) 690-9430
F: (210) 690-2919

Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, don't hesitate to ask.

Patient Information:

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____

Home Phone_____ Cell Phone _____

Address _____

City _____ State_____ Zip _____

Email _____ Driver's License # _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about our office?

☐ Google ☐ BeeFamilyDentistry.com ☐ Insurance/Medicaid Website ☐ Drive By ☐ Flyer/Mailer

☐ Friend/Patient _____ ☐ Other _____

Insurance Information:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec. # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

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I authorize payment of dental benefits by my insurance provider to be paid directly to Bee Family Dentistry.

Sign _____ Date _____

I understand and agree that I am ultimately responsible for the balance of my account. I certify that the information I have provided is true and correct. Payment is expected at the time of service unless prior arrangements have been made. Accounts 30 days past due are subject to a $25 late fee and will be turned over for collection after 60 days.

Sign _____ Date _____

I acknowledge that I have received a copy of the Bee Family Dentistry Notice of Privacy Practices and may request a copy for my own records.

Sign_____Date_____

In order to respect every patient's appointment time, no-shows may be charged a $25 fee. We require 24 hours notice for cancellations.

Multiple no-shows can be cause for dismissal from the practice.

Sign _____ Date _____