



SEXTON DENTAL

GENERAL DENTISTRY

John C. Sexton, DDS

PATIENT INFORMATION:

Patient Name: _____ Preferred Name: _____ Date: _____

Sex: M F Age: _____ Birth date: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Email Address: _____

Occupation: _____ Employer: _____

Person Financially responsible for the account: _____

Address: _____

Emergency Contact Name: _____ Phone # for ER contact: _____

Relationship of ER contact to patient: _____

Who may we thank for referring you to our office: _____

DENTAL INSURANCE INFORMATION:

PRIMARY:

Policy Holder: _____ DOB : _____

SS#: _____ Employer: _____

Insurance company: _____

Phone #: _____ Group #: _____

SECONDARY:

Policy Holder: _____ DOB : _____

SS#: _____ Employer: _____

Insurance company: _____

Phone #: _____ Group #: _____

FINANCIAL POLICY:

Thank you for choosing our office as your dental health care provider. We are committed to providing you with honest, high quality dentistry. We feel that excellent office/patient communication is essential to assist our patients in receiving optimal dental care with the least amount of confusion. Please understand that payment of your account is considered part of your treatment.

- Payment for treatment is due at the time of service. We accept cash, check, Mastercard, Visa, Discover, and American Express. Additionally, outside financing is available upon request and approval.
- If you have insurance, you are required to pay your estimated patient portion, if any, at the time of service. Please understand that any estimate of insurance payment given by our office is in no way a guarantee of payment that may be received. You are also responsible for any balance not paid by your insurance.
- Please be aware that any balance left delinquent, for any reason, will be forwarded to a collection agency. Our office reserves the right to determine what amount of time is considered delinquent – usually 90 days.
- We accept any insurance that allows our patients to see the dentist of their choice. It is always the patients’ responsibility to understand the specific terms of your insurance plan.
- As a courtesy to our patients, we will submit to the insurance carrier of their choice. It is the patients’ responsibility to provide all necessary information so we can submit claim accurately.
- Please be aware that if you give us incorrect or incomplete insurance information, you will be required to pay for your visit in full, at the time of service. You can personally submit to your insurance for any reimbursement.
- We are happy to assist you with any questions you may have regarding your insurance within our knowledge, however your insurance carrier is the only source you should rely on for answers to your benefit questions. Remember, dental insurance is considered a contract between you and the insurance carrier that your employer has selected.
- We require that any patient under the age 18 be accompanied by a parent/guardian in order to receive care. A minor may receive care only if the parent brings a note of consent.
- We also expect that if a minor is unaccompanied, that he/she have means available to make any payment due at that appointment.

WE REQUIRE AT LEAST 48 HRS NOTICE FOR CANCELLED APPOINTMENTS TO AVOID A \$50 CHARGE TO YOUR ACCOUNT.

DENTAL HISTORY

How we can help you today? (Chief Complaint): _____ Former Dentist: _____

Date of last visit: _____ Date of last dental Xrays: _____

Please mark if you have had or currently have any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Jaw joint pain/clicking/popping | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Teeth grinding/clenching | <input type="checkbox"/> Sensitivity to cold/sweets |
| <input type="checkbox"/> Broken teeth/filling | <input type="checkbox"/> Swollen/tender/bleeding gums | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Root Canal Therapy |
| <input type="checkbox"/> Food/floss catch between teeth | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Bumps/Growths |

On a scale of 1-10, with 10 being the highest:

How would you rate your current dental health: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How important is your dental health to you: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Where do you want your dental health to be: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If I could change my smile, I would:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Make them whiter | <input type="checkbox"/> Make them straighter | <input type="checkbox"/> Close spaces | <input type="checkbox"/> Replace metal fillings with tooth-colored restorations |
| <input type="checkbox"/> Repair chipped teeth | <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Replace old crowns that don't match | <input type="checkbox"/> Have a smile makeover |

MEDICAL HISTORY

Please check any that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Artificial valves/joints | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Defect | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pregnant Currently | <input type="checkbox"/> Stomach Problems/Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> HPV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Smoker/Tobacco products |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pre-Medicare for visits |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Jaundice | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other: _____ |

Drug Allergies: Aspirin Codeine Keflex Latex Local anesthetic Penicillin Sulfa Iodine Other _____

Physician's Name: _____ Physician's Phone Number _____ Date of Last Exam: _____

Are you currently under the care of a physician, if yes please describe _____

Please list any medications and the corresponding reason: _____

CONSENT AND ACKNOWLEDGEMENT (In reference to all patients-please read and sign)

I have reviewed the health information on this form, and have completed it to the best of my knowledge. I understand that this information will be used by the Doctor and his staff to determine appropriate dental treatment for myself or dependant. I understand that all of the information provided will be held in the strictest of confidence. If anything changes regarding my health, it is my responsibility to inform the Doctor and staff accordingly. I authorize Dr. John Sexton to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. John Sexton and his staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of dental anesthetic agents embodies a certain risk. I have reviewed the financial policies stated on this form and agree to all terms and conditions. If I have insurance, I authorize my insurance company to pay my benefits to Dr. John Sexton, otherwise payable to me, for services rendered. I authorize Dr. John Sexton and staff to release any and all information necessary to my insurance company, if any, strictly for the purpose of acquiring reimbursement for dental services. I fully understand the responsibility for payment for dental services provided in this office for myself or dependants is mine, due and payable at the time of service.

Patient Signature (or parent/guardian) _____ 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 the office's Notice of Privacy Practices which would apply to myself and/or dependant.

Please print patient's name

Signature of patient or guardian

Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the 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 explain):
- _____
- _____

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www.sexton-dental.com