Tom C. Sexton, D.M.D., Orthodontics and Pediatric Dentistry

PATIENT INFORMATION Today's date:____________

Patient Name: ________________________________ Age:____ Patient Birthday____________

Cell Phone: _____________ Home Phone: ______________ Work Phone:________________

Patient Address: ____

Email: __________________________________

Previous Dentist: ___________________ Physician:_________________________________

Who may we thank for referring you:____

Person Responsible for Account: (If other than patient)

Name and Address:____

Relationship to patient:_____________________________ SSN#:____________________

Work Phone: ______________ Cell Phone: ______________ Home Phone:______________

Employer's Name and Address:____

Other parent/guardian or contact:

Name and Address:____

Relationship to patient:________________ SSN:______________

Cell Phone: __________________Work Phone: ___________Cell Phone:________________

Employer's Name and Address:____

Health History	**Yes**	**No**
Is a physician treating the patient at this time?	☐	☐
If yes, why?____		
Has the patient ever been a patient in a hospital?	☐	☐
If yes, why?____		
Is the patient taking any medications at this time?	☐	☐
Name of med & dosage____		
Is the patient allergic to anything? (Medicine, food, etc.)	☐	☐
If yes, what?____		
Has the patient ever had a blood transfusion?	☐	☐
Does the patient smoke or use tobacco products?	☐	☐
Has the patient ever been seen by a dentist before?	☐	☐
Date last seen_____________ Name of Dentist_____________________		
Has the patient ever received fluoride in any form?	☐	☐
If yes, what and when?_______________________________________		
Has the patient ever had any unusual dental experiences?	☐	☐
If yes, explain____		
What are the patient's or parent's main concerns regarding the jaws and teeth?____		
Does the patient have difficulty swallowing?	☐	☐
Does the patient have difficulty chewing?	☐	☐
Does the patient have pain in the jaw joint?	☐	☐

Does the patient have any of the following?

Lip biting or sucking_______________ Grinding of teeth_____________

Tongue thrusting__________________ Thumb or finger habit_________

Medical

Has the patient ever been diagnosed as having any of the following conditions?
Please circle those that apply.

Aids	Eye Problems	Rheumatic Fever
Anemia	Excessive Bleeding	Scoliosis
Allergy	Fainting	Scarlet Fever
Arthritis	Heart murmur/disease	Sickle Cell Anemia
Asthma	Hearing Loss	Sinus Problems
Autism	Hemophilia	Snoring at Night
Brain Injury	Hepatitis-Type____	Sore Throats-Frequent
Bronchitis	Jaundice	Spina Bifida
Cancer or Chemo	Latex allergy	Syndrome
Cerebral Palsy	Mumps	Tetanus
Chicken Pox	Mouth Breathing	Tuberculosis
Cleft Lip/Palate	Nutritional Deficiency	Venereal Disease
Convulsions/Seizures	Orthopedic Problems	Whooping Cough
Diabetes	Pneumonia	Other______________
Diphtheria	Polio	___________________
Drug or Alcohol Abuse	Pregnant	
Epilepsy	Psychiatric Disorder	

Is there anything else that you think we should know about the patient?________________________

By signing below, I certify that I have read and understand the above questions. I will not hold Dr. Sexton or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

Payment

- Payment is due in full at each appointment as services are rendered.
- We accept Master Card, Visa, American Express and Discover
- A charge of $25 will be assessed on checks returned for any reason.
- A $10 late fee will be charged on all accounts 30 days past due. This office reserves the right of usage of any collection agency chosen and the below signed is solely responsible for charges incurred. Also, where appropriate, credit bureau reports may be obtained.

Dental Insurance

- Please bring your insurance card and insurance benefits booklet to your first visit.
- After we verify your dental insurance, we will file for you. However, when services are rendered we require the estimated percentage that your insurance does not cover.
- If insurance does not cover the cost of treatment, you will be responsible for the services rendered on that day.

Cancellation Policy

- We require **2 business-days** to cancel or reschedule all pediatric appointments, or **$50.00** will be charged to your account. (This does not apply to orthodontic appointments.)

Permission is hereby granted to the doctor to perform an examination and any necessary dental/orthodontic work after consultation. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for services to me will be immediately due and payable.

______________________________	______________________________	______________
Signature of Parent or Legal Guardian	**Please print name**	Date

INSURANCE INFORMATION

MUST BE FILLED OUT COMPLETELY
or you will be asked to pay in full at time of service.

Today's date ______________

Patient Name: ____

Employee's Information (Policy Holder)

Name of Employee:________________________________ Employees Date of Birth:_____________

Home Address:____

Social Security #:____________________Member ID #(on insurance card)______________________

Employed by:_____________________________________

Insurance Company:__________________________________Policy/Group#:______________

Address to send claims:____

Insurance Co. Telephone:_____________________________

Relationship to patient ___________________________

I hereby authorize release of any information relating to this claim.

____

Employees Signature

I hereby authorize all insurance benefit payments to be made to Dr. Sexton.

____

Employees Signature

******IF THE PATIENT IS COVERED BY A SECOND INSURANCE CARRIER, PLEASE ASK FOR AN ADDITIONAL INSURANCE INFORMATION FORM.**