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

PATIENT INFORMATION Today's date:____________

Patient's Name:_________________________________ Patient Number:__________________
Age:___________ Birthday:_______________ Sex:_____________
Patient's Address:____
Contact numbers: Home phone: ___________Cell number: _____________
May we text the above cell number to confirm appointments? Yes_____ No_____
Dentist: _______________________ Physician:____
How did you hear about us?___________or Who may we thank for referring you? _____________
Have we seen other family members in our office? _______________________________________

Person Financially Responsible for Account:
Name _______________________Birthday___________Address__________________________
Relationship to patient:_______________SSN:________________Email: ____________________
Cell Phone __________________Home Phone:________________Work Phone:__________________
Employer's Name and Address:_________________________________ _____________________

Other parent/guardian or contact:
Name and Address:____
Relationship to patient:_______________SSN:__________________Email:__________________
Cell Phone ________________Home Phone:_________________ Work Phone:__________________
Employer's Name and Address:____

Name and Relationship of adult that will bring patient to appointments _______________________

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.

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

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 **24 hours** *(of your scheduled appointment time)* to cancel all pediatric appointments to avoid a **$50.00 charge.** Monday appointments must be cancelled no later than the prior Thursday as we are closed on Fridays. *Thank you in advance!*

Permission is hereby granted to the doctor to perform an examination, x-rays 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

Today's date ______________

Patient Name; __________________________________

Employee's Information (Policy Holder)

Name of Employee:________________________________ Date of Birth_____________

Relationship to patient ___________________________

Home
Address:____

Social Security #:_____________________**Member ID#** (on insurance card) ______________________

Employed by:_____________________________________

Insurance Company:__________________________________Policy/Group#:______________

Address to send claims:____

Insurance Co. Telephone:_____________________________

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