Patient # **Patient Information** **Today's Date:**_____

Patient Name: _____ Age:_____ PatientBirthday:_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Address: _____ City,State,Zip: _____

Sex: _____ SSN: _____

Dentist: _____ Physician: _____

How did you hear about us?_____or Who may we thank for referring you?_____

Responsible Party Information

Person Responsible for Account

Name and Address:_____
Relationship to Patient:_____ SSN:_____ Home Phone:_____
Work Phone:_____ Cell Phone:_____ E-mail:_____
Employer's Name:_____

Other Parent, Legal Guardian, or Contact

Name and Address:_____
Relationship to Patient:_____ SSN:_____ Home Phone:_____
Work Phone:_____ Cell Phone:_____ E-mail:_____
Employer's Name:_____

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 medication and 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 do 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	Scarlet Fever
Allergy	Fainting	Scoliosis
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/Chemo	Latex Sensitivity	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? _____

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.

The complete financial responsibility for treatment in our office is assumed by the patient/parent. It is our policy to receive payment for professional services when the services are rendered unless previous arrangements have been made. As a courtesy to you, our office will gladly file your insurance for you, however we do **REQUIRE** you to pay the day the services are rendered an estimated percentage and all charges that your insurance company does not cover. It must be understood that the Doctor has no relationship with your insurance company and the fees are the sole responsibility of the undersigned. If at anytime you have any questions concerning services rendered, fees, etc., please feel free to discuss them with us.

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and American Express.

Please note: A charge of $25.00 will be assessed on checks returned for any reason. A $10.00 late fee will be charged on all accounts that are 30 days past due. We reserve the right of usage of any collection agency of our choice and the below signed is solely responsible for charges incurred. I understand that where appropriate, credit bureau reports may be obtained.

To allow for more efficient scheduling, **OFFICE POLICY REQUIRES 2 BUSINESS DAYS** to cancel or reschedule dental appointments.

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 rendered to me will be immediately due and payable.

We appreciate your choosing Dr. Sexton for your dental care and we thank you for adhering to our policies.

_____ _____ _____

Signature of Parent or Legal Guardian Please Print Name Date

INSURANCE INFORMATION

In order to assist you in filing your insurance, the following
MUST BE FILLED OUT COMPLETELY.

Today's Date: _____

Patient Name: _____

Employee's Information (Policy Holder):

Name of Employee: _____ Employee's Date of Birth: _____

Relationship to patient:_____

Social Security #: _____ Member ID #: _____

Employed by: _____ Work Telephone: _____

Insurance Company: _____

Policy/Group #: _____

Address to send claims: _____

Insurance Company Telephone: _____

If there is a second insurance: Primary:_____ Secondary:_____

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

_____

Employees Signature

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

_____

Employees Signature

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