

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

Patient # \_\_\_\_\_ **PATIENT INFORMATION** Today's date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Patient Birthday \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Physician: \_\_\_\_\_  
How were you referred to our practice? \_\_\_\_\_

**Responsible Party Information**

Father's Name and Address: \_\_\_\_\_  
How long at this address: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer's Name and Address: \_\_\_\_\_  
Mother's Name and Address: \_\_\_\_\_  
How long at this address: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer's Name and Address: \_\_\_\_\_

**History**

	<b>Yes</b>	<b>No</b>
Is a physician treating the patient at this time? If yes, why? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever been a patient in a hospital? If yes, why? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient taking any medications at this time? Name of med & dosage _____	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient allergic to anything? (Medicine, food, etc.) If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient smoke or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever been seen by a dentist before? Date last seen _____ Name of Dentist _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever received fluoride in any form? If yes, what and when? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had any unusual dental experiences? If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
What are the patient's or parent's main concerns regarding the jaws and teeth? _____		
Does the patient have difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have difficulty chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have pain in the jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>
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           | Scarlet Fever         |
| Anemia                | Excessive Bleeding     | Scoliosis             |
| Allergy               | Fainting               | Sickle Cell Anemia    |
| Arthritis             | Heart murmur/disease   | Sinus Problems        |
| Asthma                | Hearing Loss           | Snoring at Night      |
| Autism                | Hemophilia             | Sore Throats-Frequent |
| Brain Injury          | Hepatitis-Type_____    | Spina Bifida          |
| Bronchitis            | Jaundice               | Syndrome              |
| Cancer or Chemo       | Mumps                  | Tetanus               |
| Cerebral Palsy        | Mouth Breathing        | Tuberculosis          |
| Chicken Pox           | Nutritional Deficiency | Venereal Disease      |
| Cleft Lip/Palate      | Orthopedic Problems    | Whooping Cough        |
| Convulsions/Seizures  | Pneumonia              | Other _____           |
| Diabetes              | Polio                  | _____                 |
| Diphtheria            | Pregnant               | Latex Allergy         |
| Drug or Alcohol Abuse | Psychiatric Disorder   |                       |
| Epilepsy              | Rheumatic Fever        |                       |

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 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.

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	<b>Please print name</b>	Date

**Tom C. Sexton, D.M.D., P.C.**

**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 Only

Name of Employee: \_\_\_\_\_ Employees Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work Telephone \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Address to send claims: \_\_\_\_\_

Insurance Co. Telephone: \_\_\_\_\_

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

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Employees Signature

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

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Employees Signature

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