GREGORY J. SEXTON, DDS

DENTAL HISTORY

1. What is the reason for your visit today?_____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
4. Previous Dentist's Name_____
   Address/State/Zip_____
   Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other lesions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? .....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
    If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
16. Is there anything else you would like us to know? Please describe. _____
    _____
    _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

GREGORY J. SEXTON, DDS

Smile Evaluation

Name_____ Date_____

1. Do you like the way your teeth look? Yes ☐ No ☐
   Explain:_____

2. Are you happy with the color of your teeth? Yes ☐ No ☐
   Explain:_____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐
   Explain:_____

4. Would you like your teeth to be straighter? Yes ☐ No ☐
   Explain:_____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
   If so, where?_____

6. Would you like your teeth to be longer? Yes ☐ No ☐
   If so, Upper____ Lower_____ Both_____?

7. Do you like the shape of your teeth? Yes ☐ No ☐
   Explain:_____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
   Explain:_____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
   Yes ☐ No ☐
   Explain:_____

10. If you could change anything about your smile, what would you change?_____
    _____

TIME 11:07 AM DATE 3/2/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

IMPORTANT DENTAL INSURANCE INFORMATON FOR OUR PATIENTS

Understanding your insurance coverage can be quite challenging. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance whenever possible for shorter turnaround times.
3. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment for fees not covered by your insurance plan at the time service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 45 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for you cooperation with your dental insurance coverage.

I hereby authorize Dr. Sexton to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Sexton. I understand I am responsible for any unpaid balance.

_____Date_____

Signature of Patient/Insured