



**BRUCE SEXTON, DDS**

**WELCOME TO THE OFFICE OF DR. BRUCE SEXTON**

**PATIENT'S FULL NAME:** \_\_\_\_\_

What name would you like our office to call you? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Best times to reach you: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

If no one, how did you hear about our office? \_\_\_\_\_

**Male Head of Household's Name :** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ For what company: \_\_\_\_\_

Work hours: \_\_\_\_\_ Work Phone: \_\_\_\_\_ May we call you there? Y N

Does this person have dental insurance through this company? Y N

If so: Dental Insurance Company: \_\_\_\_\_

Their Address: \_\_\_\_\_

Your Group Number: \_\_\_\_\_

Who does this policy cover: \_\_\_\_\_

**Female Head of Household's Name :** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ For what company: \_\_\_\_\_

Work hours: \_\_\_\_\_ Work Phone: \_\_\_\_\_ May we call you there? Y N

Does this person have dental insurance through this company? Y N

If so: Dental Insurance Company: \_\_\_\_\_

Their Address: \_\_\_\_\_

Your Group Number: \_\_\_\_\_

Who does this policy cover: \_\_\_\_\_

*In Case of Emergency*, who should we contact? \_\_\_\_\_

Their phone number: \_\_\_\_\_ Their relationship to you: \_\_\_\_\_

**YOUR DENTAL HISTORY**

How do you feel about keeping your teeth? Important Not Important Don't Know

Do your gums bleed when you brush your teeth? Yes No

Have you ever been treated for gum disease? Yes No When? \_\_\_\_\_

Do you use tobacco products? Yes No What? \_\_\_\_\_

Have you ever had Orthodontic work?(braces) Yes No

Do you own/wear any dental appliances including:

dentures, partials, bite splints or night guards? Yes No

Do you clench or grind your teeth? Yes No

Do you have frequent or severe headaches? Yes No

Does your jaw: click pop lock

Do you use any of the following regularly:

Toothbrush Mechanical Toothbrush Dental Floss Fluoride Products Other



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**YOUR HEALTH HISTORY**

When was your last medical check up? \_\_\_\_\_  
Name of your family physician: \_\_\_\_\_  
His or Her address: \_\_\_\_\_  
His or Her phone number: \_\_\_\_\_

Please answer ALL of the following, and explain any yes answers.

- Yes No Have you had any general or serious health problems in the last five years?  
If so, what was the problem: \_\_\_\_\_
- Yes No Are you under the care of a physician at this time?  
If so, for what? \_\_\_\_\_
- Yes No Has your doctor ever required you to take special medication before a dental  
appointment? Why? \_\_\_\_\_
- Yes No Did you have a blood transfusion prior to 1992?
- Yes No Have you ever had radiation or chemotherapy? When? \_\_\_\_\_  
For what? \_\_\_\_\_
- Yes No Do you have any artificial prostheses (joints, plates, screws?)  
Where? \_\_\_\_\_ Date placed? \_\_\_\_\_
- Yes No Do you have Diabetes? If so, are you Insulin dependent? Yes No
- Yes No Does Diabetes run in your family? Who? \_\_\_\_\_
- Yes No Have you ever been treated for drug or alcohol abuse?

Do you have any allergies to Medication? Y N  
If so, please list \_\_\_\_\_

**WOMEN:**

- \_\_\_ Could you be pregnant?  
\_\_\_ Are you taking oral contraceptives (birth control pills)?  
\_\_\_ Are you taking hormonal replacement therapy?

Check if you have, or have had any of the following

- |   |   |
|---|---|
| ___ Heart trouble, heart attack, stroke   | ___ Rheumatic fever/heart disease           |
| ___ Open Heart Surgery                    | ___ Unexplained weight loss                 |
| ___ Asthma or Hay fever                   | ___ Abnormal bleeding, prolonged healing    |
| ___ Fainting spells or seizures           | ___ Easily bruised                          |
| ___ Artificial heart or valve replacement | ___ Hepatitis, Jaundice, or liver disease   |
| ___ Arthritis                             | ___ Sores that did not heal within one week |
| ___ Positive test for HIV (aids virus)    | ___ Fever of unknown origin                 |
| ___ Chest pains, shortness of breath      | ___ Anemia or other blood disorders         |
| ___ High blood pressure                   | ___ Low blood pressure                      |
| ___ Positive skin test for tuberculosis   | ___ Persistent cough or bloody cough        |
| ___ Previous Endocarditis                 | ___ Cold, canker, or Herpes sores           |
| ___ Tuberculosis, or other lung ailments  |   |



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Please list the prescribed Medications you are currently taking and What they are for:

Please list the over the counter drugs, herbs, supplements, and recreational or street drugs you are currently taking or using

Do you have any disease, condition, or problem not listed that you feel we should be aware of or that might affect your health at the time of your dental treatment?

The information given is correct to the best of my knowledge. It is my responsibility to notify this office of any change in my medical status. I understand that this information will remain strictly confidential.

I understand that my dental insurance is an agreement between my insurance company and myself. I agree to be responsible for fees charged, regardless of my insurance involvement. I assign dental benefit payments to be paid directly to Dr. Bruce Sexton. I also understand that I may be charged a 1.5% rebilling fee per month on any outstanding balance.

I acknowledge that scheduled appointment times are important not only to myself but also the Doctor, his team and his other patients. I agree to be responsible for my appointments. I understand that frequent cancellations and missed appointments can lead to loss of appointment rights.

I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or his staff to take any necessary diagnostic photos or study models to enable complete diagnosis and treatment and to use any photos or models for educational purposes.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Smile Evaluation**

1. Do you like the way your teeth look? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
2. Do you like the shape of your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
3. Are you interested in having “whiter” teeth? Yes \_\_\_\_\_ No \_\_\_\_\_
  
4. Would you like any spaces in your teeth closed? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
5. Would you like your teeth to be longer? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, Upper \_\_\_\_\_ Lower \_\_\_\_\_ Both \_\_\_\_\_
  
6. Would you like your teeth to be straighter? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
7. Do you have missing teeth you would like to have replaced? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
8. Are there any stains on your teeth that bother you? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
9. Do you have old silver fillings you would like to have replaced with tooth colored fillings? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain:
  
10. Have you ever worn a full or partial denture? Yes \_\_\_\_\_ No \_\_\_\_\_
  
11. Are you happy with the fit/comfort of your removable appliance? Yes \_\_\_\_\_ No \_\_\_\_\_
  
12. If you could change one thing about your smile or your teeth, what would it be?