



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 them 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

Are you nervous about having dental treatment? Y N Why? _____

How long has it been since your last dental visit? _____

What was done at that time? _____

When was your last dental cleaning? _____

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? Yes No

What? _____

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

Are you having any discomfort or pain at this time? _____

If so, please describe the problem: _____

YOUR HEALTH HISTORY

When was your last medical check up? _____

Name of your family physician: _____

His or Her address: _____

His or Her phone #: _____

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?

Yes No Have you ever taken Phen Phen or other prescribed diet drugs

Check if you are allergic to:

___ Penicillin ___ Codeine ___ Dental Anesthetic ___ Latex

What other drugs are you allergic to: _____

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 (Circle appropriate condition):

___ Rheumatic fever/heart disease

___ Abnormal bleeding, prolonged healing

___ Easily bruised

___ Heart trouble, heart attack, stroke

___ Asthma or Hay fever

___ Fainting spells or seizures

___ Artificial heart or valve replacement

___ Hepatitis, Jaundice, or liver disease

___ Heart murmur or Mitral Valve prolapse

___ Arthritis

___ Chest pains, shortness of breath

___ Tuberculosis, or other lung ailments

___ High blood pressure

___ Positive skin test for tuberculosis

___ Low blood pressure

___ Persistent cough or bloody cough

___ Anemia or other blood disorders

___ Cold, canker, or Herpes sores

___ Fever of unknown origin

___ Positive test for HIV (aids virus)

___ Unexplained weight loss

___ Sores that did not heal within one week

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 staff 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: _____