WELCOME TO THE OFFICE OF DR. BRUCE SEXTON

Last Name: ___________________________________ First Name: ___________________________ Middle Initial: _____

Preferred Name: ____________ Address: ____

Best Phone# to reach you: ________________Home#_______________ Cell#_______________ Work#_____________

E-mail address: ____

Gender: ___M ___F Marital Status: ___Single ___ Married ___Separated ___Divorced ___Widowed

D.O.B._____________ SS #_______________________

Student Status: ___ Full Time ___ Part time ___ N/A

Referred By: ____

***Person Responsible for Account*: ____**

Phone#_______________Address____

Relationship to Patient: ______________________________________

***In Case of Emergency*, who should we contact? ____**

Their phone number: ____________________ Their relationship to you: _____________________

Insurance Subscriber Information:

Name: ____DOB____________SS#_________________________________

Relationship to patient:__________________________

Employer Name: _____________________________________Shift:______________Phone#_______________________

Employment Status: ____ Full Time ___ Part time ___ Retired ___ N/A

Insurance Company: ____Phone#_______________________________

Address: ____

ID#____Group#_________________________

Secondary Insurance Information (If Applicable):

Name: ____DOB___________SS#___________________________________

Relationship to patient: __________________________

Employer Name: _____________________________________Shift:______________Phone#_______________________

Employment Status: ___ Full Time ___ Part time ___ Retired ___ N/A

Insurance Company: ____Phone#_______________________________

Address: ____

ID#____Group#_________________________

YOUR DENTAL HISTORY

Are you nervous about having dental treatment: ____ Yes ____ No
When was your last dental visit?___________________What was done at that time?_______________
Are you in any pain or discomfort? ____ Yes ____ No Location___________________
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?__________________
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: ○ hurt ○ click ○ pop ○ lock
Do you use any of the following regularly:
○ Toothbrush ○ Mechanical Toothbrush ○ Dental Floss ○ Fluoride Products ○ Other

What do you like about your smile?____

If there is anything about your smile that you could change, what would it be?________________________________

YOUR HEALTH HISTORY

When was your last medical checkup?____
Name of your family physician:____
Phone #:___________________________location:_________________________________

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?
Please explain:____
____ Yes ____ No Are you under the care of a physician at this time?
If so, for what?____
____ Yes ____ No Do you have any allergies to Medication?
If so, please list____

Please list the prescribed <u>Medications</u> you are currently taking and <u>what they are for</u>:
____
____
____
____

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

Check any of the following which apply in either the past or present:

- ○ **Abnormal Bleeding, Prolonged Healing**
- ○ **Alcohol Abuse**
- ○ **Anemia or other blood disorders**
- ○ **Arthritis**
- ○ **Artificial Heart or Valve Replacement**
- ○ **Asthma**
- ○ **Birth Control**
- ○ **Blood Thinner**
- ○ **Chest pains, Shortness of breath**
- ○ **Cold/Canker sores**
- ○ **Daily Aspirin Use**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ **Fainting Spells, Seizures**
- ○ **Heart Trouble, Heart Attack or Stroke**
- ○ **Hepatitis, Jaundice or Liver Disease**
- ○ **High Blood Pressure**
- ○ **Hormonal Replacement Therapy**
- ○ **Low Blood Pressure**
- ○ **Open Heart Surgery**
- ○ **Persistent Cough/Bloody Cough**
- ○ **Positive test for HIV (Aids Virus)**
- ○ **Pregnant**
- ○ **Previous Endocarditis**
- ○ **Radiation/Chemo Therapy**
- ○ **Rheumatic Fever/Heart Disease**
- ○ **Seasonal Allergies**
- ○ **Sores that did not heal within 1 week**
- ○ **Tobacco Use**
- ○ **Tuberculosis or Positive Skin test**
- ○ **Use of Boniva or Fosamax**

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?

Patient Acknowledgement and Consent Form

***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.**

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

______________________________ _________________________________

Patient Signature **Patient Name (please print)**

Date: ___________________________

Bruce Sexton, D.D.S
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

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We will not retaliate against you for filing a complaint.

Effective Date ______________________ Publication Date ______________________