

Sexson

Orthodontics, Ltd.

Smiles With Style

Welcome to Sexson Orthodontics!

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. The better we communicate, the better we can care for you.

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY.



Tell Us About You

Today's Date: _____ Male Female
Name: _____
Last First MI
I prefer to be called: _____
Birthdate: ____/____/____ Age: _____
HM#: () _____ WK#: () _____
Cell #: () _____ E-mail: _____
SS#: _____ DL#: _____
Home Address: _____
City State Zip
Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
When and where are best times to reach you? _____
Other family members seen by us: _____
General Dentist: _____ Office #: () _____
Address: _____
City State Zip
Last visit date: _____
How did you hear about Sexson Orthodontics? _____



Person Responsible For Account

Name: _____ Relation: _____
Billing Address: _____
City State Zip
Hm#: () _____ WK#: () _____
Cell #: () _____ E-mail: _____
SS#: _____ DL#: _____



Orthodontic Insurance Coverage

Yes No

Primary Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
City State Zip
Insurance Co. Phone #: () _____
Group # (Plan, Local or Policy#): _____
ID#: _____
Policy Owner's Name: _____
Relationship to patient: _____
Policy Owner's DOB ____/____/____ SS#: _____
Employer: _____
Employer Address: _____
City State Zip

Secondary Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
City State Zip
Insurance Co. Phone #: () _____
Group # (Plan, Local or Policy#): _____
ID#: _____
Policy Owner's Name: _____
Relationship to patient: _____
Policy Owner's DOB ____/____/____ SS#: _____
Employer: _____
Employer Address: _____
City State Zip



Spouse Information

Name: _____
Last First MI
Birthdate: ____/____/____ SS#: _____
Cell #: () _____ E-mail: _____
WK#: () _____ Employer: _____
Employer's Address: _____



*In the event of an emergency,
is there someone that we should contact?*

Name: _____ Relation: _____
WK#: () _____ HM#: () _____

Medical History



Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: () _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? _____

If so, please explain: _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please List: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|---|---------------------------------|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joints | Y N Hemophilia/Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma / Arthritis | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+ / AIDS |
| Y N Cancer / Chemotherapy | Y N Hospitalized for Any Reason |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes/ Tuberculosis (TB) | Y N Mitral Valve Problems |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug / Alcohol Abuse | Y N Rheumatic / Scarlet Fever |
| Y N Emphysema / Glaucoma | Y N Severe / Frequent Headaches |
| Y N Epilepsy / Seizures / Fainting Spells | Y N Shingles |
| Y N Fever Blisters / Herpes | Y N Sinus Problems |
| Y N Heart Attack / Stroke | Y N Ulcers / Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____



Medical History Continued

Are you allergic to any of the following?

- | | | |
|-----------------------|------------------------|----------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillan |
| Y N Any Metal/Plastic | Y N Erythromycin | Y N Codeine |
| Y N Tetracycline | Y N Latex | Y N Other |

Please list any other drugs that you are allergic to : _____



Dental History

What are the main concerns that you would like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment?
Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your:
(Please Circle) Mouth Teeth Chin

Do you have any speech problems? _____

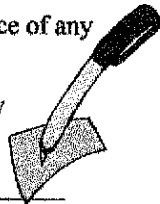
Do you generally breathe through your mouth? (Please Circle One)
Awake? Y N Asleep? Y N

Do you have any missing or extra permanent teeth? Yes No

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that I will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the orthodontic staff to perform the necessary orthodontic services I may need.



Patient Signature

Date

The Individual who signs the Contract is Solely responsible for payment.

Medical History Update:

1. Date: _____ Patient Signature _____

Comments: _____

2. Date: _____ Patient Signature _____

Comments: _____

OFFICE USE ONLY -- OFFICE USE ONLY -- OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor Signature

Date

Doctor's comments: _____

Medical History Update:

1. Date: _____ Doctor Signature _____

Comments: _____

2. Date: _____ Doctor Signature _____

Comments: _____