Sexson
Orthodontics, Ltd.
Smiles With Style

Welcome to Sexson Orthodontics!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. The better we communicate, the better we can care for your child. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY.

Tell Us About Your Child

Today's Date: ____________ Male Female

Child's Name: ______________________________
Last First MI

Nickname: ______________________________

Birthdate: ____/____/____ Age: ________

HM#: ( ) ____________ SS#: ____________

Home Address: ______________________________

____
City State Zip

General Dentist: ____________ Office #: ( ) ________

Address: ______________________________

____
City State Zip

Last visit date: ____________

Who Is Accompanying Your Child Today?

Name: ____________ Relation: ________

Do you have legal custody of this child? Yes No

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

List brothers / sisters with age: ______________________________

____

How did you hear about Sexson Orthodontics? ____________

Parental Information

Mother ☐ StepMom ☐ Guardian ☐

Name: ______________________________
Last First MI

Birthdate: ___/___/___ Home #: ( ) ________

Cell #: ( ) ________ E-mail: ________

WK#: ( ) ________ Employer: ________

Father ☐ StepDad ☐ Guardian ☐

Name: ______________________________
Last First MI

Birthdate: ___/___/___ Home #: ( ) ________

Cell #: ( ) ________ E-mail: ________

WK#: ( ) ________ Employer: ________

Who is responsible for making appts?

Name: ____________ Relation: ________

Best # to contact: ( ) ____________

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

Medical History

Child's Physician: ____________________

Phone #: ( ) ____________ Date of last visit: ________

Your child's current physical health is:

☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ________

If so, please explain: ____________________

Please list all drugs that your child is currently taking: ________

____

____

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	HIV+ / AIDS
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	Hemophilia
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

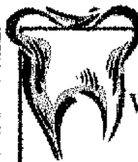
____

____

Please list all drugs / things that your child is allergic to: ____________

____

____



Dental History

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

____

Has your child ever been evaluated or had orthodontic treatment before?

Yes No

List any musical instruments played: ____________

Has your child ever experienced pain/ discomfort in his/her jaw joint (TMJ/TMD)?
Yes No

Have adenoids or tonsils been removed? Yes No

Have there been any injuries to the:

(Please Circle) Mouth Teeth Face Chin

Does your child have any missing or extra permanent teeth? `Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Does / did your child have any of the following habits?

Y	N	Clenching/Grinding Teeth	Y	N	Nursing / Bottle Habit
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrusting

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

Name: ____________ Relation: ____________

WK#: ( ) ____________ HM#: ( ) ____________

Our office is commited 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 child's medical status.

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

____________________ ____________

Parent/ Guardian Signature Date

Medical History Update:

1. Date: ________ Parent Signature ____________

Comments: ____________________

2. Date: ________ Parent Signature ____________

Comments: ____________________

The Parent or Guardian who signs the Contract is Solely responsible for payment.

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

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

____________________ ____________

Doctor Signature Date

Doctor's comments: ____________________

____

Medical History Update:

1. Date: ________ Doctor Signature ____________

Comments: ____________________

2. Date: ________ Doctor Signature ____________

Comments: ____________________

TELL US ALL ABOUT YOU!!

Your Name: ______________________________ Your Birthday: ______________

1. Do you have a nickname? ____
2. What is your favorite type of music? ______________________________
3. Who is your favorite performer? __________________________________
4. What is your favorite sport or game? ______________________________
5. Do you have any heroes? ____
6. What do you like to do in your spare time? ______________________________
7. Do you have any pets? What kinds? What names? ______________________
8. What do you like best about school? ________________________________
9. Do you have any friends or relatives that come to our office? Who? ________
10. To me, having braces would be...____
11. Is there anything special you want us to know about you? __________________

____

Thank you for giving us the opportunity to get to know you better! We look forward to helping you get to know us better as well!

Dr. Sexson and Staff