J. ALAN SEXTON D.D.S.

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient _____
Last Name First Middle Preferred Name/Goes By

Sex [ ]M [ ]F Age_____Birth Date _____ SS# _____ Marital Status _____

Home Address _____City _____ State_____Zip_____

Home Phone_____Cell _____ Email_____

Employer _____Occupation _____Work Phone _____

How do you prefer to be contacted? Mark **all** that apply. [ ]Home [ ]Office [ ]Cell [ ]Text [ ]Email

Person Responsible for Account _____ Relationship to Patient _____

Spouse Name_____Phone _____

In case of **emergency**, who should be notified?_____Phone _____

Whom may we thank for referring you? _____

Physician's Name_____ Phone _____ Last Physical _____/_____/_____

How often did your previous dentist recommend you get your teeth cleaned? [ ]3months [ ]4months [ ]6months [ ]Other _____

Last Dental Visit _____/_____/_____ Last Dental Cleaning _____/_____/_____ Previous Dentist Name _____

If you would like us to request dental records from your previous dentist/dental office, please provide their contact info below.

_____
Address Phone# Fax# Email

Dental Insurance Information

Primary Insured Name _____ Dental Insurance Name _____

Primary Insured DOB _____ Dental Insurance Phone_____

Primary Insured SSN# _____ Dental Insurance Subscriber ID# _____

Primary Insured Employer _____ Dental Insurance Policy / Group#_____

Are you allergic to any of the following?

No[ ] Yes[ ] Codeine
No[ ] Yes[ ] Iodine
No[ ] Yes[ ] Tylenol
No[ ] Yes[ ] Latex (Gloves / Adhesive / Tape)
No[ ] Yes[ ] Metals
No[ ] Yes[ ] Aspirin
No[ ] Yes[ ] Anesthetic (Novocain, etc.)
No[ ] Yes[ ] Tetracycline
No[ ] Yes[ ] Penicillin, Amoxicillin, other antibiotics

If yes, please describe allergic reaction _____

Other medical allergies not listed above _____

Please list all medications you are taking and for what reason.

Medication / Reason for Taking	**Medication / Reason for Taking**
_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

PATIENT REGISTRATION AND MEDICAL HISTORY

Have you ever had any of the following?

No[ ] Yes[ ] Heart Problems
No[ ] Yes[ ] Pacemaker
No[ ] Yes[ ] Artificial Heart Valve/Artificial Joint
No[ ] Yes[ ] Circulatory Problems
No[ ] Yes[ ] Mitral Valve Prolapse
No[ ] Yes[ ] Radiation Treatment
No[ ] Yes[ ] High Blood Pressure
No[ ] Yes[ ] Scarlet Fever/Rheumatic Fever
No[ ] Yes[ ] Excessive Bleeding
No[ ] Yes[ ] Blood Disease
No[ ] Yes[ ] Psychiatric Care/Nervous Problems
No[ ] Yes[ ] Hepatitis, Jaundice / Liver Disease
No[ ] Yes[ ] Asthma/Respiratory Disease
No[ ] Yes[ ] A.I.D.S./HIV or Other Immunosuppressive Disorders
No[ ] Yes[ ] Stroke
No[ ] Yes[ ] Tuberculosis
No[ ] Yes[ ] Sinus Problems
No[ ] Yes[ ] Arthritis
No[ ] Yes[ ] Anemia
No[ ] Yes[ ] Headaches
No[ ] Yes[ ] Low Blood Pressure
No[ ] Yes[ ] Epilepsy
No[ ] Yes[ ] Back Problems
No[ ] Yes[ ] Diabetes
No[ ] Yes[ ] Fainting Spell
No[ ] Yes[ ] Swollen Neck Glands
No[ ] Yes[ ] Chemical Dependency
No[ ] Yes[ ] Cancer

Please answer the following questions

No[ ] Yes[ ] Other than routine visits, are you under the care of a physician? If yes, please describe _____
No[ ] Yes[ ] Women: Are you pregnant? If yes, due date: _____
No[ ] Yes[ ] Women: Are you nursing?
No[ ] Yes[ ] Have you been advised by your physician to take antibiotics before having any dental treatment?
If yes, please indicate reason: _____
No[ ] Yes[ ] Have you ever experienced a problem with local anesthesia? If yes, please describe:_____
No[ ] Yes[ ] Do you have pain/clicking when opening or closing your jaw? If yes, please describe:_____
No[ ] Yes[ ] Have you ever had TMJ treatment? If yes, please describe:_____
No[ ] Yes[ ] Do you have frequent headaches? If yes, please describe: _____
No[ ] Yes[ ] Do you have any discomfort in your mouth presently? If yes, please describe:_____
No[ ] Yes[ ] Are your teeth sensitive to heat? Cold? Sweets? If yes, please describe:_____
No[ ] Yes[ ] Are your teeth sensitive when biting/chewing? If yes, please describe:_____
No[ ] Yes[ ] Have you ever had orthodontics/braces?
No[ ] Yes[ ] Do your gums bleed when brushing/flossing? If yes, please describe: _____
How often do you brush your teeth? _____ When? _____
How often do you floss your teeth? _____ When? _____
No[ ] Yes[ ] Have you ever been diagnosed as having periodontal disease? If yes, please describe: _____
No[ ] Yes[ ] Have you ever had periodontal surgery? **If Yes, please describe:**_____
No[ ] Yes[ ] Do you grind or clench your teeth? **If Yes, please describe:** _____
No[ ] Yes[ ] Do you get blisters on the lips or in your mouth? **If Yes, please describe:** _____
No[ ] Yes[ ] Do you have removable dental appliances? **If Yes, please describe:** _____
No[ ] Yes[ ] Are you happy with your smile? **If No, please describe:**_____
No[ ] Yes[ ] Do you drink alcohol? If yes, how much/often _____
No[ ] Yes[ ] Do you use tobacco products? If yes, what type: _____How much/often: _____
No[ ] Yes[ ] **Is there anything special you would like to discuss today? If Yes, please indicate:**_____

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including X-rays) and evaluation of my dental health. Furthermore, I understand that payment is due at the time that services are rendered. I also understand that I will incur an 18% finance charge if my balance goes beyond 60 days.

_____ _____ _____
Signature of patient, parent or guardian **Date** **If parent/guardian, relationship to patient**

J. ALAN SEXTON D.D.S.

INSURANCE AND FINANCIAL RESPONSIBILITY

The office of J. Alan Sexton, D.D.S. is dedicated to providing optimal care for every patient and we pride ourselves in working on your behalf to offer the quality of care that you deserve. We appreciate the opportunity to be your dental provider and wish to encourage you to contact us if there are ever questions regarding treatment or payment of treatment.

As a courtesy to you, our office will continually strive to help you understand and secure the full benefits of your dental insurance. Because insurance policies vary greatly, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. As is customary in professional offices, arrangements for payment of your fees must be made at the time of treatment.

Although our office does not participate in any Preferred Provider Organization (PPO) or Dental Maintenance Organization (DMO), we welcome you as a patient. However, please be advised that if you participate in such a plan, you may receive reduced benefits by seeking treatment from doctors outside your plan. You are responsible for paying all charges not covered by your particular insurance company, including all fees considered above your insurance company's usual and customary fee schedule.

To further assist you, our office will complete and submit dental claims forms to the insurance company for you to achieve the maximum reimbursement to which you are entitled and will work diligently to expedite this process. However, be aware that some dental insurance companies take longer than others to complete payment. If necessary, our office will contact the dental insurance company on your behalf, or we may request your assistance in this matter.

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and in continuing to provide the quality of care that you deserve. Please let us know if you have any questions – it will be our pleasure to help you.

- I understand that my insurance benefits are a contract between me and my employer. The amount of coverage I receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor. I also understand that I am responsible for the balance of my dental account regardless of my insurance.
- If we have not received payment from your insurance company within 60 days of service, any unpaid balance will be due and payable by the responsible party at that time. After this payment has been received, we will continue to assist you in receiving your insurance benefits which will then be payable directly to you.
- A finance charge of 1.5% per month will be applied to my account on any unpaid balance due after 90 days whether it is my portion or a portion that I believe to be the responsibility of my insurance company.
- I assign dental benefit payments to be paid directly to Dr. J. Alan Sexton from my insurance company.
- Payment for all services is due at the time treatment is performed. Cash, check, MasterCard, Visa and Discover are accepted. There will be a $30 service fee for all returned checks.

I have read the above information and understand that all charges for treatment and any additional charges are my responsibility.

_____	_____	_____
Signature of patient, parent or guardian	**Date**	**If parent/guardian, relationship to patient**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I/On behalf of_____ , have received a copy of this office's Notice of Privacy Practices.
(Print Patient's Name)

Patient Signature _____ **Date** _____

~ or ~

Parent/Guardian Print Name _____ **Relationship to Patient**_____

Parent/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY – THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information: We use and disclose health information about you for treatment, payment, and healthcare operations, such as:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. We may also use your personal and/or health information to electronically, or by telephone, verify insurance benefits, file insurance claims, and check status of your insurance claims.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it, in writing, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Your Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

KEEP THIS PAGE FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others.

National Security: We may disclose to military authorities, the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required or lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, answering machine messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $5.00 for each page, $10.00 per hour for staff time to locate and copy health information and postage if you want the information mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information and charge a fee for this. Contact us by using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations- you must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanations how payment will be handled for the alternative means or location you request.

Amendments: You have the right to request that we amend you health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints: If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: J. Alan Sexton, DDS, 3555 Timmons Lane, Suite 1080, Houston, TX 77046. Telephone (713)993-9777

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