DELAWARE DENTAL
GENERAL DENTISTRY

PATIENT INFORMATION:

Patient Name: _____ Preferred Name: _____ Date: _____

Sex: M ☐ F ☐ Age: _____ Birthdate: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work: (___) _____ Other: (___) _____

Email Address: _____ Occupation: _____

Employer: _____ Employer Address: _____

Spouse (Parent/Guardian) Name: _____ Birthday: _____ SS#: _____

Person Financially responsible for the account: _____

Address: _____

Emergency Contact Name and Number: _____ Relation to patient: _____

Who may we thank for referring you to our office: _____

DENTAL INSURANCE INFORMATION:

PRIMARY:

INSURED NAME: _____ DOB: _____

SS#: _____ EMPLOYER: _____

INSURED COMPANY: _____

COMPANY ADDRESS: _____

PHONE#: _____ GROUP#: _____

SECONDARY:

INSURED NAME: _____ DOB: _____

SS#: _____ EMPLOYER: _____

INSURED COMPANY: _____

COMPANY ADDRESS: _____

PHONE#: _____ GROUP#: _____

FINANCIAL POLICY:

Thank you for choosing our office as your dental health care provider. We are committed to providing you with honest, high quality dentistry. We feel that excellent office/patient communication is essential to assist our patients in receiving optimal dental care with the least amount of confusion. Please understand that payment of your account is considered part of your treatment.

- Payment for treatment is due at the time of service. We accept cash, check, Mastercard, Visa, Discover, and American Express. Additionally, outside financing is available upon request and approval.
- If you have insurance, you are required to pay your estimated patient portion, if any, at the time of service. Please understand that any estimate of insurance payment given by our office is in no way a guarantee of payment that may be received. You are also responsible for any balance not paid by your insurance.
- Please be aware that any balance left delinquent, for any reason, will be forwarded to a collection agency. Our office reserves the right to determine what amount of time is considered delinquent – usually 90 days.
- We accept any insurance that allows our patients to see the dentist of their choice. It is always the patients' responsibility to understand the specific terms of your insurance plan.
- As a courtesy to our patients, we will submit to the insurance carrier of their choice. It is the patients' responsibility to provide all necessary information so we can submit claim accurately.
- Please be aware that if you give us incorrect or incomplete insurance information, you will be required to pay for your visit in full, at the time of service. You can personally submit to your insurance for any reimbursement.
- We are happy to assist you with any questions you may have regarding your insurance within our knowledge, however your insurance carrier is the only source you should rely on for answers to your benefit questions. Remember, dental insurance is considered a contract between you and the insurance carrier that your employer has selected.
- We require that any patient under the age 18 be accompanied by a parent/guardian in order to receive care. A minor may receive care only if the parent brings a note of consent.
- We also expect that if a minor is unaccompanied, that he/she have means available to make any payment due at that appointment.

WE REQUIRE AT LEAST 48 HRS NOTICE FOR CANCELLED APPOINTMENTS TO AVOID A $50 CHARGE TO YOUR ACCOUNT.

DENTAL HISTORY

How we can help you today? (Chief Complaint): _____ Former Dentist: _____

Date of last visit: _____ Date of last dental Xrays: _____

Please mark if you have had or currently have any of the following:

- ☐ Bad Breath
- ☐ Snoring
- ☐ Broken teeth/fillings
- ☐ Orthodontic Treatment
- ☐ Food/floss catch between teeth
- ☐ Jaw joint pain/clicking/popping
- ☐ Teeth grinding/clenching
- ☐ Swollen/tender/bleeding gums
- ☐ Periodontal Treatment
- ☐ Dry Mouth
- ☐ Loose teeth
- ☐ Sensitivity to cold/sweets
- ☐ Sensitivity to biting
- ☐ Root Canal Therapy
- ☐ Bumps/Growths

On a scale of 1-10, with 10 being the highest:

How would you rate your current dental health: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How important is your dental health to you: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Where do you want your dental health to be: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If I could change my smile, I would:

☐ Make them whiter ☐ Make them straighter ☐ Close spaces ☐ Replace metal fillings with tooth-colored restorations

☐ Repair chipped teeth ☐ Replace missing teeth ☐ Replace old crowns that don't match ☐ Have a smile makeover

BP: _____

MEDICAL HISTORY

Date/Staff _____

Please check any that apply to you:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial valves/joints
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Blood disease
- ☐ Bruise easily
- ☐ Stroke
- ☐ Smoker
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Thyroid Disease
- ☐ Tobacco products
- ☐ Heart Conditions
- ☐ Heart Defect
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Pre-Medicate for visits
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant Currently
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Stomach Problems/Ulcers
- ☐ Venereal Disease
- ☐ Other _____

Drug Allergies: ☐Aspirin ☐Codeine ☐Keflex ☐Latex ☐Local anesthetic ☐Penicillin ☐ Sulfa ☐ Iodine ☐Other_____

Physician's Name: _____Physician's Phone Number_____ Date of Last Exam: _____

Are you currently under the care of a physician, if yes please describe _____

Please list any medications and the corresponding reason: _____

_____

_____

CONSENT AND ACKNOWLEDGEMENT (In reference to all patients-please read and sign)

I have reviewed the health information on this form, and have completed it to the best of my knowledge. I understand that this information will be used by the Doctor and his staff to determine appropriate dental treatment for myself or dependant. I understand that all of the information provided will be held in the strictest of confidence. If anything changes regarding my health, it is my responsibility to inform the Doctor and staff accordingly. I authorize Dr. John Sexton to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. John Sexton and his staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of dental anesthetic agents embodies a certain risk. I have reviewed the financial policies stated on this form and agree to all terms and conditions. If I have insurance, I authorize my insurance company to pay my benefits to Dr. John Sexton, otherwise payable to me, for services rendered. I authorize Dr. John Sexton and staff to release any and all information necessary to my insurance company, if any, strictly for the purpose of acquiring reimbursement for dental services. I fully understand the responsibility for payment for dental services provided in this office for myself or dependants is mine, due and payable at the time of service.

Patient Signature (parent/guardian of child) _____ Date _____