Registered by:_____

Data Verified & Entered By: _____

Patient #: _____

Date: _____

SEXTON DENTAL CLINIC INC.

IV SEDATION

****All patients requesting partial dentures and/or extractions will be required to have x-rays.****

I fully understand the purpose of x-rays and their diagnostic value in dental medicine and surgery. If the dentist requires an x-ray prior to treatment, I give my permission to have the x-rays taken.

Signature of Patient: _____ Date:_____

Patient Requested Dental Treatment: (please circle)

Complete Upper Denture	Upper Partial	Extractions	Consultation
Complete Lower Denture	Lower Partial	Reline/Adjustment	
Consultation	Were you scheduled for IV Sedation_____?		

Patient's Initials _____

PATIENT INFORMATION (Photo identification is required.)

Name _____ Age ____ Date of Birth___/___/___ Sex:_____Male_____Female
First MI Last

Street Address: _____ City_____ State___ Zip_____ Telephone # (____) ____-____

Height:_____Weight _____ Email: _____ Cell # (____) ____-____

Social Security No.____-____-_____(for identification purposes only) Marital Status___Single___Married___Widowed___Divorced___Separated

Occupation: _____ Employer _____

Is this your first visit to Sexton Dental Clinic?___If not, please list the approximate date of your last dental visit and the name of the dentist you were treated by:_____.

Why did you come to our office today? **(Chief dental complaint.)** _____

Date of last dental examination_____Name of dentist_____

Do you have SC Medicaid?_____If yes, please list your Medicaid ID Number _____

How did you hear about our office?___Phonebook ___Internet ___Friend(_____) ___Other(_____)

MEDICAL HISTORY

Please answer all questions, (circle Yes or No), and fill in all blank spaces where indicated. Answers to these questions are for our records only and are kept confidential.

Do you have or have you ever had any of the following Diseases or Conditions?

Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Asthma or Hay Fever	Yes	No
Heart Attack	Yes	No	High/Low Blood Pressure	Yes	No	Diabetes	Yes	No
Hepatitis	Yes	No	Stomach Ulcers	Yes	No	Kidney Trouble	Yes	No
Tuberculosis	Yes	No	Venereal Disease	Yes	No	Respiratory Trouble	Yes	No
Anemia	Yes	No	Sickle cell Disease	Yes	No	Cancer	Yes	No
Radiation/Chemotherapy	Yes	No	Stroke	Yes	No	Sinus Problems	Yes	No
Psychiatric Problems	Yes	No	HIV/AIDS/ARC	Yes	No	Blood Transfusion	Yes	No
Drug/Alcohol Abuse	Yes	No	Thyroid Problems	Yes	No	Herpes	Yes	No
Orthopedic Surgery	Yes	No	Mitrovalve Prolapse	Yes	No	Glaucoma	Yes	No
Are you Pregnant?	Yes	No						

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____If so, please list all drug allergies and describe the adverse reaction. _____

_____.

Are you allergic to Latex? Yes No (please circle)

Are you currently taking any medications?_____If yes, please list ALL medications. _____.

Are you taking any blood thinners (Aspirin, Plavix, Coumadin, etc)? ____Yes ____No. If yes, please list_____

Are you taking or have you ever taken any bisphosphonates (Fosamax, Zometa, Didronel, Aredia, Actonel, Boniva, Reclast)? Yes No

Date of last physical examination____/____/____. Are you currently under the care of a physician? ____Yes ____No
If yes, what condition is being treated?_____
Name of your physician:_____Physician's Telephone No. (_____)_____-_____
Have you been hospitalized within the last five years? ___Yes ___No
If yes, please list the reason you were hospitalized _____.
Is there anything else we should know about your medical history? _____
_____.

Is this office visit accident related?___Yes ___No
If yes, please list the date and nature of accident_____.

CONSENT TO ACCURACY AND DISCLOSURE OF PATIENT INFORMATION

The information I have provided is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance benefits I am entitled to. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of my personal health information.

Signature of Patient: _____Date: _____

If a personal representative signs this authorization on behalf of the patient, please complete the following:

Personal Representative's Name: _____Relationship to Patient: _____

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Sexton Dental Clinic, Inc. may only use and disclose your protected health information as follows:

1. Directly to you (the patient)
2. To carry our treatment, payment, or healthcare operations
3. In compliance with a patient authorization form
4. When you (the patient) is informed in advance of the proposed disclosure and has the opportunity to agree or disagree.
5. When the disclosure is required by law or for public health reason.

Therefore, Sexton Dental Clinic, Inc.'s doctors and staff are not permitted to discuss your dental treatment or any issues related to your dental treatment with your family members, friends, etc. without your written authorization.

If you wish to authorize such uses and disclosures, please ask a receptionist for a "Patient Authorization Form".

Signature of Patient: _____Date: _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?			
Date of last physical exam:			

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: _____

Immediate Partial and Complete Denture Consent

FYC – FOR YOUR CONSIDERATION

1. Immediate Dentures are intended for use during the immediate phase which is the 12 months following extraction of the teeth. At 12 months post extraction discontinue use of the Immediate Denture and obtain a new denture. This new denture is loosely referred to as the Permanent denture and is expected to yield good service for at least five years with proper care and routine follow-up with the dentist.
2. Immediate Dentures are loose when they are delivered to the mouth and become looser over time due to the resorption (shrinkage) of the dental arches that occurs post extraction during the **Immediate Phase**.
3. The use of denture adhesive will be required to aid in the fit of immediate dentures.
4. It is advisable to keep the Immediate Denture in the oral Cavity day and night for the first five days. **Remove the denture to clean it and the oral cavity after meals and then apply new denture adhesive and replace the denture in the oral cavity. If the denture is causing ulceration of the gingiva (gums) discontinue use and return to the office ASAP.**
5. After the first five days of denture use, remove the denture at night and place it in water or a denture cleaning solution while you sleep. Failure to give the gingiva (gums) and the crestal ridge (dental arch) adequate rest from the denture may lead to soft tissue symptoms (Denture Stomatitis) and can hasten the rate of crestal bone resorption.
6. There is a definite learning curve to effective use of dentures. Until an individual learns to accommodate the denture, the denture may feel alien to the oral cavity and changes in speech and function are expected.
7. Subsequent new dentures will feel different than the previous dentures and will require time to accommodate as well.
8. **Individuals choosing to have all of their Mandibular teeth (lower jaw) replaced with a complete denture should consider future placement of at least two dental implants to aid in denture retention as the lower denture is very unstable.**
9. Routine follow-up with the dentist is critical for optimal oral health and denture performance.
10. Denture patients at Sexton Dental Clinic receive free adjustments for the first three months and the reline at three months is also free.

Immediate Partial and Complete Denture Consent

(Two Pages)

When a tooth is extracted the bone supporting that tooth shrinks in both height and width as it heals. This shrinkage – referred to as **resorption** – continues throughout life. If one has some or all of their teeth removed, in preparation for a partial or complete denture for example, it should be understood that the shape and size of the crestal ridges (arches) will change dramatically over time. Note the upper jaw is called the Maxilla and the lower jaw is called the Mandible. For the remainder of this discussion, both Partial and Complete dentures will simply be referred to as Denture. Immediately following extraction, the resorption will occur at a very rapid rate and leads to rapid and dramatic changes in the architecture of the crestal ridge that supports the denture. Over time the rate of resorption will approach zero, or no change at all; however, it will never be zero. This is referred to as **The Steady State of Resorption (SSR)**. When an individual reaches SSR, the bone resorbes at a much slower rate and it appears as though it is not changing at all. Individuals reach SSR independent of one another; however, it is reasonable to expect most individuals to reach SSR by about 12 months post extraction. This 12 month healing period is referred to as **The Immediate Phase**. Any denture fabricated for an individual during the Immediate Phase is referred to as an **Immediate Denture** and is only intended for use during the Immediate Phase. Routine adjustments to the Immediate denture are required as an individual progresses through the Immediate Phase and the most critical of these adjustment appointments, **The Reline appointment**, should occur approximately 3 months post extraction. A reline of the Immediate Denture is an attempt to modify the tissue surface of the denture to mirror the changes of the crestal ridge that supports the denture. This is accomplished by placing an auto-cure acrylic liner in the Immediate Denture and placing the Immediate Denture back in the mouth like an impression. The acrylic will cure and chemically bond to the Immediate Denture and, upon removal from the mouth, any excess acrylic will be removed. This process essentially retro-fits the Immediate Denture to accommodate for the resorption that has occurred in the first three months of the Immediate Phase. At the end of the Immediate Phase (12 months) it is necessary to discontinue use of the Immediate Denture and seek a new denture. Some refer to this new denture as their **Permanent Denture**, recognizing of-course, it is not permanent. It is recommended that individuals with a denture make routine follow-up visits to ensure the denture continues to fit properly and when necessary a new denture should be fabricated for optimal oral health. It is reasonable to expect a denture fabricated for an individual that has reached SSR to yield good results for at least five years with proper care and follow-up with the dentist.

Sexton Dental Clinic IV SEDATION FAQ

1. Will I be seen by the dentist at the time I am appointed to be at the office?

   Individuals choosing to have full or partial dentures should understand that it takes an incredible amount of work to produce these prostheses in one day. No appointments are necessary for those individuals that either do not require extractions or decide to have their extractions completed while awake and simply given a local anesthetic to facilitate their extractions. Although an appointment is not required, we recommend you present to the office as early as possible to allow sufficient time to complete your care.

   However, individuals choosing to have teeth extracted with Sexton Dental Clinic's IV Sedation Team do require an appointment. The appointment time is usually set early in the morning. Again, this is to ensure your care can be completed in one day. Please note that your appointment time is the time the Sedation Team needs you to present to the office. It is not the time you will meet the doctor. Be assured that every effort will be made to render your care in a timely manner with compassion and dignity.

   Note: Those individuals that do not require one day care may choose to divide the steps necessary to render their care over multiple days. Rather than spend the entire day at Sexton Dental Clinic, you may choose a number of shorter appointments over a number of days.

2. What should I expect when I present to Sexton Dental Clinic for extractions and Full or Partial Dentures?

   You will begin by registration at the front desk. Once you complete your chart and are registered you will be introduced to Dr. Clark. He, along with Caitlin and Tracy, comprise the IV Sedation Team. Dr. Clark and Tracy will review your Medical and Dental Histories with you and complete an exam of your oral structures. They will then discuss treatment options with you.

   Should you require extractions as a part of your treatment and you choose to complete those extractions with the IV Sedation Team, you will be directed to the IV Sedation Department following some preliminary work with the Denture Team. The Denture Team will make impressions of your oral cavity, complete occlusal records (measure how your teeth bite together), and discuss options such as the color of the prosthetic teeth to be placed on your Full or Partial Denture. You will then be directed back to the IV Sedation Team for the surgical Phase of your procedure.

   Plan to dress warm. The temp in the IV Sedation department tends to be COLD. Consider long pants, socks, comfortable shoes, and a light jacket or sweater.

   When you arrive in the Sedation Department, you and your escort will be directed to the IV Sedation waiting room. By the time you reach this step, Dr. Clark and Tracy will have put you in line for your surgical phase. You may be one of a number of individuals that will present for IV Sedation; therefore, you may have somewhat of a wait before you are called back to begin your surgical procedure. Dr. Clark and Tracy are fully aware that IV Sedation Patients are not to have any food or liquid twelve hours prior to the procedure. Therefore they do not shut down for lunch when the rest of the Clinic does.

They make every effort to treat you in a reasonable amount of time; however, each person is given 100% attention while with Dr. Clark to ensure a quality outcome which may result in some wait-time.

Once you are admitted to the surgical area, you will be introduced to a CRNA (Certified Registered Nurse Anesthetist). The CRNA will review your Medical History and discuss the procedure of Sedation. Once Dr. Clark, Tracy, the CRNA, and you are prepared to start your procedure, you will be sedated. When you wake up, the procedure will be completed and you will have no memory of the procedure. You will then be reunited with your escort and back with the Denture Team. As soon as your Full or Partial Dentures are ready for delivery to you, the Denture Team will assist you in that endeavor later in the day. The entire process typically requires the entire business day. A 24 hour re-eval is recommended.

3. What if I need some teeth fixed and some teeth extracted? Can that be done on the same day?

   Restorative Care (fixing your teeth) is accomplished in the Restorative Department by Dr. Brian Terry. If you suspect that you need restorative care, it is necessary to obtain an appointment with the Restorative Department by calling (843) 656-1943 or 1-866-634-3846.

   If you suspect that you require a combination of restorative care and extractions, you must coordinate with both departments. In other words, you must have appointments with both the Restorative Department and the IV Sedation Department. We recommend the appointment for restorative precede the appointment with the IV Sedation Department.

4. How can I be sure of what my dental needs are before I see the dentists at Sexton Dental Clinic?

   If you are planning to travel a great distance to have your dental care completed at Sexton Dental Clinic, some preliminary planning on your part will definitely make your experience a better one. We call it the Five P's. **P**rior **P**lanning **P**revents **P**oor **P**erformance.

   We suggest a visit to your local dentist for an exam and X-Ray. You may snail-mail, email, or FAX a copy of each to Dr. Clark. Dr. Clark will review the exam and X-Ray and he or one of his staff will contact you to discuss treatment options and streamline your visit to Sexton Dental Clinic. Note, there is no charge for this pre-clinical work up and if you bring the hard copy of your current X-Ray (X-Ray must be less than 6 months old), you will not be charged an X-ray fee when you present for treatment here at Sexton Dental Clinic.

   Mail, email, Fax:

   Dr. J. Robert Clark @ Sexton Dental Clinic
   377 W Palmetto St.
   Florence, SC 29501
   Fax: (843) 656-0110
   Email: ivsedationsc@gmail.com

5. Can I be assured that my care will be completed in one day?

   Individuals that present to Sexton Dental Clinic for extraction and Partial or Complete Dentures are routinely completed in one day. However, if an individual needs complex care – a combination of restorative, surgical, and prosthetic (dentures) care – treatment times will be longer; perhaps days or weeks. See question #2, #3, and #4.

6. Is IV Sedation safe?

   Every effort is made to ensure patient safety. In many dental offices, the dentist is responsible for sedating the patient as well as performing the dental therapy. Here at Sexton Dental IV Sedation we employ a CRNA (Certified Registered Nurse Anesthetist) for sedation which enables Dr. Clark to focus more on the task at hand. However, be assured that Dr. Clark, Tracy, and the CRNA share the task of monitoring the patient during sedation and all are appropriately trained to do so. Additionally, each person on the treatment team is current in BLS and ACLS (Basic Life Support and Advanced Cardiac Life Support).

7. What drugs are used for sedation at Sexton Dental Clinic?

   Sedation is routinely achieved using Propofol. Adjunct medications are also used dependent upon individual patient's needs.

8. Is Dr. Clark an Oral Surgeon?

   Dr. Clark is a General Dentist. He received his training in Charleston, South Carolina at the Medical University of South Carolina. He began his practice at Sexton Dental Clinic in 1999. He is currently responsible for the IV Sedation Department and the Implant Department.

9. Why can't I eat or drink for 12 hours prior to presenting to the Clinic for IV Sedation?

   SAFETY! During IV Sedation there is a risk that the stomach contents may regurgitate. If this happens it can lead to aspiration of those fluids and solids into your lungs. This could result in a pneumonia or death.

10. Why must I have an Escort with me if I choose IV Sedation at Sexton Dental Clinic?

    When you awake from IV Sedation, you will still be somewhat sedate as if you had taken an oral sedation medication like Valium. Your Escort will be responsible for you 12 hours after your procedure. It would not be wise for you to operate heavy equipment such as driving a car or make important financial decisions for 24 hours following sedation.

    Prepare your Escort to be at the Clinic ALL DAY. It may be wise for your Escort to eat breakfast before they present to the clinic with you and pack food, drink, and other necessities that they may require. We have vending machines but no cafeteria. A well prepared Escort reduces stress on the patient.

SEXTON DENTAL CLINIC MEDICAL CONSULTATION REQUEST
COVER SHEET

From John Robert Clark, Jr. DMD. Sexton Dental Clinic 377 W. Palmetto Street Florence, SC.

Phone: 843-656-1932 Fax: 843-656-0110
Email: IVsedation@sextondental.net

TO:_____ RE:_____

Fax:_____ DOB:_____

Doctor:
Please be advised that your patient listed above has expressed an interest in seeking dental care with us here at Sexton Dental Clinic. It is common for prospective patients to travel quite a distance to visit us; therefore, they desire to complete as much preclinical work as possible prior to presenting to our office for examination as a matter of their convenience. In an effort to be as accommodating as possible, we routinely request information regarding the individual's health history prior to their visit with us.

Please note that it is likely you are also receiving this request because the prospective patient expects to be sedated (conscious sedation) for exodontia and/or other minor oral surgical procedures such as exostosis removal in preparation for treatment with Complete or Partial Dentures. Ordinarily, local anesthesia is obtained with 2% Lidocaine with 1:100,000 epinephrine. Conscious Sedation is routinely achieved using Propofol. Adjunct medications are also used dependent on individual patient's needs. Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases.

Patient Consent:

I agree to the release of my medical information to Sexton dental clinic.

Signature and Date_____

SEXTON DENTAL CLINIC MEDICAL CONSULTATION REQUEST

To: Dr._____

_____

RE:_____

Please complete the form below and return it to:

Dr. J. Robert Clark, Jr.

Phone: 843-656-1932
Fax: 843-656-0110
Email: IVsedation@sextondental.net

PHYSICIAN'S RESPONSE

PLEASE CHECK ALL THAT APPLY

— To the best of my knowledge, the patient may proceed with dental treatment including minor oral surgical procedures without any special precautions.
— Uncontrolled Diabetes.
— Sleep Apnea CPAP (YES) (NO)
— COPD
— Infectious Disease
  — HIV/AIDS (CD4) =_____Date_____
  — Hepatitis (Type) _____ (Acute/Carrier)
  — TB (PPD+/Active)

— Antibiotic prophylaxis is recommended due to:

_____

— Patient has vascular stent. (circle one) Drug Eluting / Non Drug Eluting
— Hx of uncontrolled Hypertension, Heart attack, or Stroke. (Please provide narrative)
— Patient currently on an anticoagulation therapy regimen.

Anticoagulant agent(s):_____

Most recent INR: Date_____ Value_____

— Recommend temporary cessation of anticoagulant regimen.
Date begin cessation_____ Date resume_____

(Dr. Clark does not routinely seek cessation of Anticoagulant Therapy especially if INR<2.5)

Physician's Signature and Date_____

7. **Sequestril** (Bone fragments) Extraction of a tooth requires that the bone surrounding it be expanded, or sometimes even fractured to allow the tooth to slip out of the socket. This may leave bone fragments still attached to the main body of the bony structure beneath. As healing begins, these fragments tend to reattach. Bony fragments that do not heal properly are often ejected from the socket. This can be painful and sometimes requires the dentist to remove it. When the fragments come out on their own, they are often mistaken for pieces of tooth. Sequestri are unavoidable and undetectable at the time of extraction. They are not considered to be a mistake the dentist made.

If you have an emergency and need to contact us after our normal operating hours, please call 843-656-2199. Leave a message and someone from our staff will contact you within a timely manner.

Thank you.

Sexton Dental Clinic Inc.

After-Extraction Information & Care

Sexton Dental Clinic Inc
377 West Palmetto St.
Florence, SC 29501
843-662-2543
800-827-1560
www.sextondental.net

Post-Operative Instructions and Information for Extraction Patients

1. When you leave the office, **you should have gauze over the extraction sockets.** Keep gently biting on the gauze to keep constant pressure on the extraction area for an hour or two. The only way to stop the bleeding is to apply pressure to these areas. If you have kept the socket(s) covered firmly for at least two hours, the blood in the socket should have clotted. The clot acts like a cork and keeps you from bleeding further. You may notice some oozing from the clot while it continues to organize itself. The blood will also mix with saliva and can appear worse than it really is.

2. Do not spit for 24 hours. The act of spitting always starts with a sucking action. This will dislodge the clot causing renewed bleeding, or even a dry socket. You may gently bring blood and saliva forward with your tongue and wipe it away with a tissue.

3. Do not smoke for 48 hours. If you smoke, you will get a dry socket because the chemicals in the smoke get into the saliva and dissolve the clot. If you have ever had a dry-socket you will do anything to avoid another one.

4. **Wait until the anesthesia wears off before eating anything solid**. When you can feel your mouth, you may eat whatever you can tolerate.

5. Take your medications. If you have been prescribed an antibiotic, take it on schedule until it is all used up. Dental infections can be not only painful, but dangerous.

Complications after Extractions

1. Bleeding: Follow post-operative instruction #1 and the bleeding will stop. Patients who are taking blood thinners or patients with bleeding disorders should consult physicians before having a tooth/or teeth extracted. People who take aspirin or NSAIDs, such as Advil or Aleve, may experience prolonged bleeding at times. If you experience a lot of heavy bleeding, you may want to try using a tea bag to control it. Wet the tea bag, squeeze out the excess water, and then bite down gently on the tea bag for as long as you can. This should help a clot to form. Do NOT use a dry tea bag because it will taste horrible and it may stick to the clot if you do not leave it in long enough.

2. Swelling: Swelling is common after any dental treatment. It is temporary and should disappear within a week. You may apply ice bags to the area (as instructed).

3. Infection: The mouth is alive with bacteria. Infection is a constant problem after extractions due to the fact that the mouth is teeming with bacteria and cannot be sterilized prior to the extraction. (Not due to any error on the part of the dentist.) Renewed bleeding or swelling and increased pain after 48 hours is a sign of possible infection. If this occurs, you should see the dentist as soon as possible.

Please take any prescribed medication with food. Taking medications on an empty stomach can cause nausea and vomiting to occur.*

4. Dry Sockets: This is a condition in which the blood clot that forms in the extraction site becomes detached from the walls of the socket or dissolves away leaving bare bone exposed to saliva and the foods you eat. The bone becomes inflamed due to bacteria and contaminants in the saliva. This inflammation is persistent and painful. The socket begins to emanate a bad odor. A dry socket is one of the most painful, common, debilitating and dreaded post extraction problems encountered in dentistry. If you get one, it is not necessarily your fault, or the fault of the dentist. They are a quirk of nature. If you get one, you may think you are going to die, but you won't. But you should return to the dentist that did your extractions for treatment.

5. Broken Jaws: It does occasionally happen. There are some situations in which the jawbone that surrounds the tooth or teeth is much more fragile than is usually the case creating a higher risk for the possibility of a jaw fracture.

6. Sinus perforation: There is a thin wall of bone between the root of the tooth and the sinus, but it can be VERY thin. Most of the time, the bone remains intact, but upon occasion, a piece of the bone separating the root from the sinus may break off and be removed with the tooth. This creates a direct connection between the sinus and the mouth. You would not be able to suck on a straw, because air would rush into your mouth from your nose through the socket. In the case of very large perforations, a further surgical procedure may be necessary and the patient may be referred to an oral surgeon.

Information for Denture Patients

How dentures are made:

The dentist will take an impression of your jaw, along with measurements of how your jaws relate to one another and how much space is between them (bite relationship). The color (shade) of your teeth will also be determined either from your natural teeth or a denture you may already be wearing. The impression, bite, and shade are given to the dental laboratory so a denture can be made just for you.

The dental laboratory makes a mold (model) of your jaw, places the teeth in a wax base, and carves the wax to the exact form in the finished denture. Any cosmetic adjustments to your preference can be made at this time if you choose to get the "cosmetic try-in" denture.

A mold of the wax-up denture is made, the wax is removed and the remaining space is filled with pink plastic in dough form. The mold is then heated to harden the plastic. The denture is then polished and ready for the patient to wear.

Wearing your dentures:

It usually takes a little while to get used to wearing a new denture. You may have to return to the dentist for minor adjustments, but after a few weeks you should be more at ease with the new denture.
Keep in mind that over time, your mouth will change. The bone and gum areas may shrink or recede, causing the space between the jaws to change. Because your denture keeps its shape, adjustments will be needed to keep your denture fitting properly. It is advisable that the denture wearer be examined every five to seven years for new dentures.

New denture patients often ask why the lower dentures seem so loose. Your lower plate, unlike the upper plate, has no suction. The gum of the upper plate makes an automatic suction with the roof of your mouth. The lower plate has no roof so it cannot create suction. You will need to learn to keep your lower plate in with your muscles and tongue.

New dentures:

New dentures may feel awkward for a few weeks until you become accustomed to them. The dentures may feel loose while the muscles of your cheek and tongue learn to keep them in place. It is not unusual to experience minor irritation or soreness. You may find the saliva flow temporarily increases. As your mouth becomes accustomed to the new dentures, the problems should diminish. One or more follow-up visits with the dentist are generally needed after a denture is inserted. If any problem persists, particularly irritation or soreness, you should return to your dentist for a denture adjustment.

Cleaning your Denture

1. Rinse your denture thoroughly after every meal.
2. Clean your denture thoroughly at least once a day, using a toothbrush and nonabrasive denture cleanser. Don't use alcohol, abrasive cleaners, bleaches, whiteners, or boiling water to clean or soak your denture.
3. Complete dentures normally should not be worn at night. They should be removed and store in normal tap water or in denture cleaning solution. Dentures can dry out and distort if they are left outside a moist environment.
4. To prevent breaking your dentures, brush them over a towel or over a sink half-filled with water. Lightly brush dentures with a soft nylon toothbrush or denture brush.
5. Massage gums daily with a soft toothbrush. Any sore red areas, burning sensations, white patches or growths need to be brought to the attention of your dentist. You still need to be seen by a dentist regularly even with complete dentures to check your mouth and to be sure your dentures fit correctly.

Dentures are very delicate and may break even if dropped even a few inches.
When you are not wearing them, store your dentures away from children and pets.
Dentures can be warped if placed in hot water.

Denture Adhesive

Denture adhesive can provide additional retention for well-fitting dentures. Denture adhesives are not the solution for old, ill-fitting dentures. A poorly fitting denture, which causes constant irritation over a long period, may contribute to the development of sores and other more serious problems.

Dentures and the way that you speak

Pronouncing certain words may require some practice. If your dentures "click" while you are talking, speak more slowly. You may find that your dentures occasionally slip when you laugh, cough, or smile. You may reposition the denture by biting down and swallowing. Adjusting to this will take time, practice, and patience.

Sexton Dental Clinic, Inc.

377 West Palmetto Street
Florence, South Carolina 29501
(843) 662-2543

905 Medical Circle
Myrtle Beach, SC 29577
(843) 449-0431

IMMEDIATE "Temporary" DENTURES

Suppose your remaining teeth unfortunately are not restorable and cannot be utilized in any way to support a partial prosthesis:
If you were to have a traditional denture made, it would be necessary to have all of these teeth extracted first. The bone and gums would have to heal and then a denture could be fabricated. This process could take several months, if not longer, and for that time period you would have to go around without teeth. In order to avoid this type of problem, we utilize an Immediate Denture. This involves taking impressions of your mouth while your teeth are still present. At the time your teeth are extracted, we have a denture ready to be inserted. In this way, you would not have to walk around without teeth. **Immediate dentures do present certain situations which you should be aware of:**

**If a patient has multiple extractions, it is not possible to do a wax try-in. The denture teeth are placed in about the same position as the natural teeth before extractions. Even though the denture teeth will be straight, and clean, their position may not be ideal because there is no way to preview them as we do with try-in dentures. For this reason, the appearance of the immediate denture may not be exactly what you expect, and you may wish to invest in a new one at the end of about a year when most of the healing has taken place.

An immediate denture is a **temporary denture. After the natural teeth are extracted and the immediate denture is inserted, there is a relatively fast loss of the bone that used to hold the natural teeth in place. After a few weeks or possibly in a few days, enough bone has been lost that there is a LOT of space between parts of the denture and the healing gums. This may lead rapidly to looseness and some/many sore spots. It is probable that patients with immediate dentures will need to use an **adhesive.** After three months, the denture may need to be relined. The hard reline is a separate procedure and is not included in the original cost of the immediate denture. Thus the immediate denture may end up costing a bit more than standard dentures.

The following are some suggestions that will aid you in making a speedy recovery:

- Do not rinse your mouth for the first 24 hours or until clotting has established.
- Do not eat or drinking anything too hot. Cool or cold liquids only. No carbonated drinks.
- No alcoholic beverages or smoking following surgery.
- Do not eat hard foods or brush the area of extractions for a few days.
- Eat soft foods, custards, gelatins, milkshakes, etc. or prepare meals in a blender.
- Drink plenty of fluids the first few days, but do not use a straw.
- Apply ice bags to the area for the first 18 hours following your surgery. After that apply heat, but be careful not to burn yourself. Use the ice and heat as directed.
- Plan on taking some time off. You will recover much faster by resting and following instructions.
- Diet supplements such as "Boost" can be found in grocery stores and pharmacies. We suggest using these to supplement your diet while healing.
- Do not take any prescription medicines on an empty stomach unless directed by your pharmacist or dentist.
- Take all medication as prescribed.

For other post-operative instructions and suggestions, please refer to the "Post Operative Instructions" given to you after your extractions.

Patients will need to return at 3 months after having immediate dentures made for a reline (at no charge). A new denture will probably be necessary in approximately one year.

SEXTON DENTAL CLINIC INC.

Privacy Officer: **Effective Date:**

This Notice describers how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we a required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you with to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, *including* disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

SEXTON DENTAL CLINIC INC.

Patient Name: _____ **Patient #** _____ **Date**_____

PAYMENT INFORMATION

Payment is to be made at the time services are rendered, We accept cash, Visa, Mastercard, Discover, American Express, and Debit cards. We do not accept dental insurance; however, if you have dental coverage, a claim may be submitted to your insurance carrier for your reimbursement. If interested, please see the insurance specialists for further information.
The claims processing fee is $8.
Person Responsible for Payment: _____Do you have dental insurance?____Yes ____No

POST OPERATIVE CARE

I,_____ , agree that should I need any denture adjustments, post-operative care and treatment, or should any complications occur, I will return to the office of Sexton Dental Clinic. I understand that I may have to make return visits for denture adjustments and/or receive post-operative surgical procedures. If I am unable to return to the office of Sexton Dental Clinic, I will accept full responsibility of any expenses that may occur by choosing to go elsewhere for treatment. I also understand that if additional dental treatment is needed during a follow-up visit, there may be a fee for this treatment as well.
Signature of Patient:_____ Date: _____

NO REFUND POLICY

Due to the customized nature of dentistry, our services and products are non-refundable and non-returnable. The No Refund policy also applies to any restorative or cosmetic treatment that is in process or has been completed. Customer satisfaction is paramount to us, and complaints will be assessed on an individual basis.

Signature of Patient:_____ Date: _____

IMMEDIATE DENTURES

I understand that when having teeth extracted that I am purchasing an Immediate Denture/partial that is neither aesthetically nor functionally perfect. I am aware that adjustments and a reline is necessary and at no additional cost if returned within 90 days. A reline can usually be done as early as two (2) weeks prior to the ninety (90) day return time. I also understand that this temporary denture/partial will need to be replaced in approximately one (1) year at my expense.
Signature of Patient:_____ Date: _____

CTI: COSMETIC TRY-IN DENTURE (not for patients having extractions)

One of the main concerns of denture wearers is the appearance of their teeth. An impression is taken and a lab-technician will set the teeth on the models according to certain anatomical landmarks for that particular patient. These anatomical landmarks are the basis for determining the size and length of the denture, etc. However, this may not coincide with what the patient has in mind in regards to the appearance of the teeth. this is the purpose for the *Cosmetic Try-In Denture* (CTI). The CTI is a little more expensive; however, it is the only way to assure the patient satisfaction with the appearance of the denture.

With CTI, the teeth are set in a wax model and "Tried In" for the patient to see. At this time, the patient can make any requests for change in the way the teeth are set.

If a patient declines the option to have the CTI, there is no guarantee the patient will be satisfied with the appearance of the new denture.

I understand that by declining the option of having a try-in denture made, there will be no guarantee that I will be satisfied with the appearance of the denture.
I decline the option of having a "try-in" denture made and I understand that appearance satisfaction is not guaranteed.

Signature of Patient:_____ Date:_____

Dental Assistant: _____ Date:_____