SIMS orthodontics #SimsationalSmiles

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☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Child Prefers to be called _____ Office ☐ Nashville ☐ Columbia

Patient Name _____
First Middle Last

☐ Male ☐ Female DOB ___ / ___ / ___ SS# _____ - ___ - _____ Home Phone _____ Cell _____

Address_____ City_____State _____ Zip _____

Email_____ Employer/School _____ Grade _____ Work Phone _____

Dentist _____
Name Address Phone

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

Children's names and birthdates of brothers and sisters _____

_____

☐ Father ☐ Guardian ☐ Spouse ☐ Stepfather ☐ Grandfather

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Name _____
First Middle Last

☐ Male ☐ Female DOB ___ / ___ / ___ SS# _____ - ___ - _____ Home Phone _____ Cell _____

Address_____ City_____State _____ Zip _____

Email_____ Employer_____ Work Phone _____

☐ Mother ☐ Guardian ☐ Spouse ☐ Stepmother ☐ Grandmother

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Name _____
First Middle Last

☐ Male ☐ Female DOB ___ / ___ / ___ SS# _____ - ___ - _____ Home Phone _____ Cell _____

Address_____ City_____State _____ Zip _____

Email_____ Employer_____ Work Phone _____

Is your insurance a form of TNCARE? ☐ Yes ☐ No Orthodontic coverage? ☐ Yes ☐ No ☐ Don't Know

Patient's Dental Ins #1 _____
Insurance Company Name State

Subscriber Name _____ Employer _____

Subscriber ID _____ DOB ___ / ___ / ___ Group # _____

Patient's Dental Ins #2 _____
Insurance Company Name State

Subscriber Name _____ Employer _____

Subscriber ID _____ DOB ___ / ___ / ___ Group # _____

Dental History

Has the patient ever had any previous orthodontic treatment or consultations? ☐ Yes ☐ No

If yes, please explain _____

_____

Has the patient had injury to the teeth, face, or head? ☐ Yes ☐ No

If yes, please explain _____

Has the patient ever had jaw joint problems? ☐ Yes ☐ No

If yes, please describe _____

Has the patient ever had periodontal therapy? ☐ Yes ☐ No

If yes, please explain _____

Does the patient suffer from frequent headaches? ☐ Yes ☐ No

If yes, please describe _____

Does the patient ever clinch or grind teeth? ☐ Yes ☐ No

If yes, please describe _____

Has the patient ever sucked their finger or thumb? ☐ Yes ☐ No

If yes, please describe _____

Does your drinking water contain fluoride? ☐ Yes ☐ No ☐ Yes ☐ Don't Know

Health History

Is the patient under the care of a physician? ☐ Yes ☐ No

If yes, please explain _____

Doctor _____ Phone_____

Please list all medications the patient is currently taking

_____

_____

Please list all known allergies

_____

_____

Has the patient ever been hospitalized? ☐ Yes ☐ No

If yes, please explain _____

Please check all that apply to patient

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐	Birth Defects
☐	☐	Heart Disease	☐	☐	Blood Transfusion	☐	☐	Cancer
☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease or Trait	☐	☐	AIDS
☐	☐	Liver Disease	☐	☐	Blood Disorders	☐	☐	Eye Problems
☐	☐	Kidney/Bladder Disease	☐	☐	Mental Retardation	☐	☐	Hearing Problems
☐	☐	Respiratory Disease	☐	☐	Cerebral Palsy	☐	☐	Cleft Lip/Palate
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Speech Problems
☐	☐	Tuberculosis	☐	☐	Diabetes	☐	☐	OTHER _____
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	OTHER _____

Consent & Acknowledgement of Receipt of Privacy Policy HIPPA

I have received and read all information given for the Hippa Privacy Policy. I have truthfully answered all of the questions and filled out all of the information on this form to be used by Sims Orthodontics for records and communications via auto-dialer, voice message, email, text and cell phone. I will inform Sims Orthodontics if there are any changes in the future. I agree to the Consultation and Complete Orthodontic Evaluation which includes photographs and X-rays to be used for diagnosis and treatment plans. I fully understand I am under no obligation to accept the treatment plan presented.

Print Name _____ Date _____

Signature _____ Relationship ☐ Parent/Guardian ☐ Self