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CHILDRENS DENTAL ASSOCIATES  
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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 clench 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

- Rheumatic Fever
- Heart Disease
- Heart Murmur
- Liver Disease
- Kidney/Bladder Disease
- Respiratory Disease
- Asthma
- Tuberculosis
- Anemia

Yes No

- Thyroid Disease
- Blood Transfusion
- Sickle Cell Disease or Trait
- Blood Disorders
- Mental Retardation
- Cerebral Palsy
- Hepatitis
- Diabetes
- Epilepsy

Yes No

- Birth Defects
- Cancer
- AIDS
- Eye Problems
- Hearing Problems
- Cleft Lip/Palate
- Speech Problems
- OTHER \_\_\_\_\_
- OTHER \_\_\_\_\_

## Consent & Acknowledgement of Receipt of Privacy Policy HIPPA

I have received and read all information given for the Hipa 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