Jeffrey D. Sims, D.D.S.,F.A.G.D.
West Vinings Dental Aesthetics

PATIENT INFORMATION FORM

Welcome! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out all forms completely. The better we communicate, the better we can care for you.

Date: ____________________

Last Name	First Name	Middle Initial
Preferred First Name	Date of Birth	SS#
Home Street Address		
City	State	Zip
Home Phone #	Cell Phone #	Fax #
E-Mail Address		
Employed By		Work Phone #
Work Address		
Who May We Thank For Referring You To Our Practice?		
Emergency Contact Full Name		
Emergency Contact Home Phone #	Cell Phone #	Work Phone #
Spouse/Significant Other Full Name		
Spouse/Significant Other Work Phone #		Cell Phone #
Who Is Financially Responsible for the Payment of Your Account?		Relationship to Patient
Home Address of Responsible Party		
Home Phone #	Cell Phone #	Work Phone #

Method of Payment for Visits: ____*Cash* ____*Check* ____*MC/Visa/Discover* ____*Dental Fee Plan*

The information I have given today is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. I hereby authorize the doctor or designated staff to take xrays, study models, bacteriological cultures, diagnostic casts, photographs, biopsies of oral tissue, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the above named patient's dental needs. Upon such diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE CHARGES IN FULL FOR THE SERVICES RENDERED. ACCEPTANCE OF ASSIGNMENT OF BENEFITS DOES NOT ABSOLVE ME OF FULL RESPONSIBILITY FOR THE CHARGES IN FULL FOR TREATMENT RENDERED.

____

Patient/Parent/Guardian Signature — Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!

Our practice is committed to meeting or exceeding the standards of the infection control mandated by OSHA, the CDC, the AGD, and the ADA.

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?--YES NO

   Physician's Name_______________________________ Phone #_________________________

   Address__________________________City____________________State_____Zip______________

2. Have you taken any medications or drugs during the past two years?--YES NO

3. Are you taking any medications, drugs, or pills now?--YES NO

   If yes, please list name and dosage____

4. ARE YOU AWARE OF HAVING AN ALLERGY (ADVERSE REACTION) TO ANY MEDICATION OR SUBSTANCE?----YES NO

   If yes, please list____

5. Have you been a patient in a hospital in the last five years?--YES NO

6. Indicate which of the following the following you have had, or have at present.

Heart (Surgery, Attack, Disease)	Y N	Ulcers	Y N	Hepatitis A, B, C	Y N
Chest Pain	Y N	Diabetes	Y N	Insomnia	Y N
Congenital Heart Disease	Y N	Thyroid Problem	Y N	AIDS	Y N
Heart Murmur	Y N	Glaucoma	Y N	HIV Positive	Y N
High Blood Pressure	Y N	Contact Lenses	Y N	Cold Sores	Y N
Mitral Valve Prolaspe	Y N	Emphysema	Y N	Blood Transfusion	Y N
Artificial Heart Valve	Y N	Chronic Cough	Y N	Hemophilia	Y N
Heart Pacemaker	Y N	Tuberculosis	Y N	Sickle Cell Disease	Y N
Rheumatic Fever	Y N	Asthma	Y N	Bruise Easily	Y N
Arthritis/Rheumatism	Y N	Hay Fever	Y N	Liver Disease	Y N
Cortisone Medicine	Y N	Latex Sensitive	Y N	Migraines	Y N
Swollen Ankles	Y N	Allergies	Y N	Neurological	Y N
Stroke	Y N	Sinus Trouble	Y N	Epilepsy/Seizures	Y N
Restricted Diet	Y N	Radiation Tx	Y N	Fainting/Dizzy	Y N
Artificial Joints	Y N	Chemotherapy	Y N	Nervous/Anxious	Y N
Kidney Trouble	Y N	Cancer/Tumor	Y N	Psychological Care	Y N
Alcoholism	Y N	Drug Addiction	Y N	Smoking Habit	Y N

7. Injuries to head or mouth?--YES NO

8. Major Surgery?--YES NO

9. Do you have or have you had any disease, condition or problem not listed?--YES NO

10. Women. Are you Pregnant? YES Months_____ NO Nursing YES NO Taking Birth Control Pills YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any health change.

____

Patient/Parent/Guardian Signature Date

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DENTAL HISTORY

Address ______________________________ Phone # ______________

Last complete oral exam ______________ Last complete radiographs ______________

Please comment on your previous dental experience(s) ______________________________

DO YOU NEED TO BE PREMEDICATED? ________YES ________NO FOR ______________

Please circle YES or NO and fill in details

Yes No Are you presently in pain? ______________________________

Yes No Have you experienced any unfavorable reaction to dentistry? ______________

Yes No Have you lost any teeth? Cause? ______________________________

Yes No Orthodontic treatment? ______________________________

Yes No Growths or swelling in the mouth? ______________________________

Yes No Difficulty swallowing? ______________________________

Yes No Bleeding gums? ______________________________

Yes No Do you avoid brushing any areas? Why? ______________________________

Yes No Have you been told you have gum disease? ______________________________

Yes No Any sensitive areas? ______________________________

Yes No Bad reaction to anesthetic? ______________________________

Yes No Areas that food catches? ______________________________

Yes No Pain or soreness around ears, eyes or other parts of the face? ______________

Yes No Pain or soreness in jaws or muscles? When? ______________________________

Yes No Awareness of clenching or grinding? When? ______________________________

Yes No Awareness of jaw clicking or popping? When? ______________________________

Yes No Difficulty opening widely? ______________________________

Yes No Habits such as nail biting? ______________________________

Yes No Tension headaches? When? ______________________________

Yes No Unpleasant taste or odor? ______________________________

Yes No Any family members wear dentures? Who? ______________________________

Yes No Are you concerned that you may eventually wear dentures? ______________

Yes No Are you dissatisfied with your teeth or their appearance? ______________

Yes No Do you want to learn to control dental disease and keep your teeth? ______________

Signature ______________________________ Date ______________