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

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

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 _____

JEFFREY D. SIMS, DDS, FAGD, PC
1198 CONCORD RD, SE
SMYRNA, GA 30080-4261
770 319-1622

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Jeffrey D. Sims D.D.S.
1675 Cumberland Parkway
Suite #104
Smyrna, GA. 30080-3439
770-319-1622

Date: _____

Name: _____ Date of Birth: _____

Please initial all that apply:

_____ I consent to receiving communication regarding my care via email.

_____ I consent to have detailed messages left on my voicemail at home.

_____ I consent to have detailed messages left on my cellular voicemail.

_____ I consent to have detailed messages left on my voicemail at work.

_____ I consent to have my care discussed with my spouse.

_____ I consent to have my care discussed with my immediate family members.

_____ I consent to have my care discussed with _____.

_____ I DO NOT want my care discussed with anyone other than myself.

By signing below you agree that you have been given the opportunity to review Dr. Jeffrey D. Sims, DDS privacy practices and HIPPA regulations. You may revoke your designation(s) at any time by written request.

Thank you for allowing Dr. Sims the opportunity to assist in your dental care.

Patient's Signature_____

West Vinings Dental Aesthetics
Dr. Jeffery Sims, DDS, FAGD

Three Important Commitments

A commitment between two people builds trust. I have three important commitments in my practice. I have put them in writing because I live by them, as does me staff. I believe that these commitments are necessary in building the trust that it takes for you and I to work together successfully.

1. **Commitment to Treatment**

   Dental disease is 100% preventable. I believe that all treatment begun should be completed. I will deliver the best dental care that I am capable of delivering and I ask that you care for your dental health on a daily basis. Incomplete treatment leads to unnecessary problems and complications, such as the loss of teeth. It also leads to more advanced disease, which unnecessarily adds to your cost and can lead to the breakdown in communication between the two of us. I know that you want as little dentistry done in your lifetime as possible. Help yourself achieve that by following through with your dental plan.

2. **Commitment to Appointment**

   I will reserve time for you. I will give you utmost attention and care and will rarely keep you waiting. An appointment scheduled in my office is a bond of trust that my staff and I will be here to serve you and that you will be on time and prepared for you appointment.

3. **Commitment to Financial Considerations**

   I believe that I have responsibility to use my best professional care, skill, and judgment in helping you achieve your dental health goals. As I have previously stated, I believe that dental disease is 100% preventable. I will deliver the best dental care that I am capable of delivering to help you attain your goals.

_____ _____

Dr. Jeffery Sims D.D.S Patient

Jeffrey D. Sims, D.D.S., F.A.G.D.
West Vinings Dental Aesthetics
1675 Cumberland Pkwy SE #104
Smyrna, Ga. 30080

Assignment of Dental Benefits

Please read, initial and sign the statements listed before we agree to accept assignment of dental benefits directly from your insurance company. This will avoid any misunderstanding and will facilitate processing of your insurance claim.
If you have any questions, please ask us.

_____I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Jeffrey Sims.

_____I understand and agree that I am responsible for the estimated amount **not** paid by the insurance company.

_____I understand that after the insurance company pays Dr. Sims, there could still be a balance remaining, for which I am responsible.

_____I understand and agree that if payments are sent directly to me (by the insurance company), I am responsible for the amount in full at that time.

_____I understand and agree that if the estimate of insurance benefits (EOB) indicates a large amount due by me and I feel I cannot pay it during treatment, I can request a written financial agreement (terms to be discussed at that time).

_____

Signature of Responsible party

_____

Financial Coordinator

_____

Date