

Amy B. Farnsworth, D.M.D, P.S.C

ORTHODONIST

Brace Yourself for a Fabulous Smile!



2700 Bardstown Road
Louisville, KY 40205
(502) 452-2116
www.farnsworthortho.com

Welcome ~ Thank you for selecting us

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions please ask us and we will be happy to help.

Adult New Patient Registration

Date: _____

Patient's Name _____ Prefers to be called _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employed by _____ Occupation _____

Social Security # _____ Birthdate _____ Age _____ Sex Male Female

Spouse's Name _____ Cell or Work Phone _____

Employed by _____ Occupation _____

Who may we contact in case of emergency? _____ Phone _____

Dentist _____ Physician _____

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

What are your orthodontic concerns? _____

Person responsible for account _____ Social Security # _____

(If other than you) Cell or Work phone _____ Home Phone _____

Address _____ City _____ St _____ Zip _____

Do you have orthodontic insurance coverage? Yes No Insured's Name _____

Social Security # _____ Birthdate _____

Name of employer _____ Name of Ins. Co. _____

Ins. Co. Phone # _____ Do you have dual coverage? Yes No

Providing us your e-mail allows you to view your account and appointment information and receive e-mail reminders about upcoming appointments and office announcements.

A simple registration e-mail will be sent to you to activate this service.

E-mail address: _____

HEALTH HISTORY

CIRCLE

1. Are you having jaw pain or discomfort at this time?..... Yes No
2. Do you feel very nervous about having ortho treatment?..... Yes No
3. Have you been a patient in the hospital during the past two years?..... Yes No
4. Have you been under the care of a medical doctor during the past two years? Yes No

Physician's Name _____

Address _____ Phone _____

5. Have you taken any medicine or drugs during the past two years?..... Yes No
If yes, please list: _____
6. Are you now taking any medication, drugs or pills? Yes No
If yes, please list: _____
7. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... Yes No
8. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

- | | | |
|---|--|---|
| Heart Trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis B..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Angina Pectoris..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High/Low Blood Pressure..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Hay Fever..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Yellow Jaundice..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Murmur..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Transfusion..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic Fever..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Allergies or Hives..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Drug Addiction..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Lesions..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Scarlet Fever..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal Disease
(Syphilis, Gonorrhea)..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Heart Valve..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Chemotherapy
(Cancer, Leukemia)..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Cold Sores..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Pacemaker..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Arthritis..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy or Seizures..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Surgery..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatism..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Fainting or Dizzy Spells..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints (Hip, Knee)..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Cortisone Medicine..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric Treatment..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Pain in Jaw Joints..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Bruise Easily..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney Trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/> | A.I.D.S. / HIV+..... Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Ulcers..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Adenoids Removed..... Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Cosmetic Surgery..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsils Removed..... Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Endocrine Disorders..... Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis A (infectious)..... Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Emphysema..... Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... Yes No
10. Are you pregnant or think you may be pregnant? Yes No
11. Do you do any of the following (please circle): heavy snoring, mouth breathing, thumb sucking, tongue thrusting? .. Yes No
12. Are you on a special diet? Yes No
13. Do you have any disease, condition or problem not listed?..... Yes No
14. Do you require premedication prior to dental cleanings? Yes No
If yes please explain: _____

NOTICE OF PRIVACY PRACTICES:

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

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I understand that where appropriate, bureau reports may be obtained. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient: _____ Date _____ Doctor Signature _____ Date _____