



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

ORTHODONTIST

"Brace Yourself for a Fabulous Smile."

2811 Bardstown Road  
(502) 452-2116

## 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 or need assistance, please ask us and we will be happy to help.

### ADULT NEW PATIENT REGISTRATION

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Prefers to be called \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Social Security \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Spouse's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Who may we contact in case of emergency? \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_

In your opinion, what is your orthodontic problem? \_\_\_\_\_

\_\_\_\_\_

Who may we thank for recommending you to our office? \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Social Security \_\_\_\_\_

(If Other Than You) Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Do you have orthodontic insurance coverage?  No  Yes, company \_\_\_\_\_

Group Number \_\_\_\_\_ Phone/Contact \_\_\_\_\_

Insured's date of birth \_\_\_\_\_

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

## 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 \_\_\_\_\_