



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

ORTHODONTIST

"Brace Yourself for a Fabulous Smile."

www.farnsworthortho.com

2811 Bardstown Road
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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.

Patient Information (Confidential)

Date: _____

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Male Female

Home Phone _____ Birthdate _____ Social Security # _____ - _____ - _____

Patient's Age _____

If student, name of school/college _____ Hobbies _____

Whom may we thank for referring you to our office? _____

Is another family member a patient at this office? Yes No Their name _____

Patient's Dentist _____ Date of last visit _____

Has patient ever sucked thumb or fingers? Until what age? _____

Responsible Party* Information

Name of person responsible for this account _____
Last First Middle

Relationship to patient _____ Birthdate _____ Social Security # _____ - _____ - _____

Address _____
Street City State Zip

Check Appropriate Box: Single Married Separated Divorced Widowed

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Name of Bank _____

Spouse's name _____ Relationship to patient _____
Last First M.I.

Social Security # _____ - _____ - _____ Birthdate _____ Work Phone _____ CellPhone _____

Employer _____ Occupation _____

*Note: The "Responsible Party" is the individual who will be making payments. If there is more than one "Responsible Party" (ie a divorce case) the parent who signs the contract is ultimately responsible for making the payments.

E-mail

Registration of your e-mail allows you to view your account and appointment info and receive e-mail reminders about upcoming appointments and office announcements.

Insurance Information

Insured's name _____ Relationship to patient _____

Social Security # _____ - _____ - _____ Birthdate _____

Name of Employer _____ Name of Ins. Co. _____

Ins. Co. Phone # _____

Group # _____ Policy/ID # _____

Do you have dual coverage?: Yes No If yes:

Insured's name _____ Relationship to patient _____

Social Security # _____ - _____ - _____ Birthdate _____

Name of Employer _____ Name of Ins. Co. _____

Ins. Co. Phone # _____

Group # _____ Policy/ID # _____

HEALTH HISTORY

CIRCLE

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

Physician's Name _____

Address _____ Phone _____

5. Has patient taken any medicine or drugs during the past two years?..... Yes No
If yes, please list: _____

6. Is patient now taking any medication, drugs or pills? Yes No
If yes, please list: _____

7. Are you aware of patient being allergic to or having you ever reacted adversely to any medication or substance? ... Yes No

8. Please circle any of the following the patient had or has at present.

Heart Trouble	Tuberculosis	Hepatitis A (infectious)
Angina Pectoris	Asthma	Hepatitis B
High Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Yellow Jaundice
Rheumatic Fever	Allergies or Hives	Blood Transfusion
Congenital Heart Lesions	Diabetes	Drug Addiction
Scarlet Fever	Thyroid Disease	Hemophilia
Artificial Heart Valve	X-ray or Cobalt Treatment	Venereal Disease
Heart Pacemaker	Chemotherapy	(Syphilis, Gonorrhea)
Heart Surgery	(Cancer, Leukemia)	Cold Sores
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery	A.I.D.S.	Bruise Easily
Endocrine Disorders	Adenoids Removed	
Emphysema	Tonsils Removed	

9. When the patient walks up stairs or takes a walk, does he ever have to stop because of pain in his chest, or shortness of breath, or because he is very tired? Yes No

10. Is the patient pregnant or do you think she may be pregnant? Yes No

11. Has the patient lost or gained more than 10 pounds in the past year? Yes No

12. Does the patient ever wake up from sleep short of breath?..... Yes No

13. Is the patient on a special diet?..... Yes No

14. Has a medical doctor ever said the patient has cancer or a tumor? Yes No

15. Does patient have any disease, condition or problem not listed? Yes No

16. Does the patient 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, credit bureau reports may be obtained.

Patient: _____ Date _____ Doctor Signature _____ Date _____

if over 18 years old

Parent or Responsible Party _____ Relationship to Patient _____