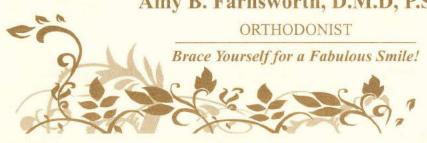
Amy B. Farnsworth, D.M.D, P.S.C



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:	Email:				
Patient's Name		Prefers to be called			
Address	City	City		Zip	
Cell Phone	Carrier	Wo			
			Yrs Employed		
Social Security #	Birthdate	Age	Sex DN	lale □Female	
Check Appropriate Box:	ISingle □Married	□Separated	□Divorced	□Widowed	
Spouse's Name	Cell Phone	Carrier			
Employed by		Occupation			
Social Security #	Birthda	ite	Ag	e	
Who may we contact in case of em	ergency?	11 15-7	Phone		
Dentist	Date of last visit?				
Whom may we thank for referring y	ou to our office?				
What are your orthodontic concern	s?				
Do you have orthodontic insurance	coverage? □Yes □No If yes,	complete all of th	e following		
Insured's Name		Birthdate			
Name of Employer	Name o	Name of Ins. Co.			
Social Security #	Ins. Co	. Phone #			

have received a copy of the HIPPA privacy practice.

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	-				MEDICAL HISTOR		
Addre	ess	V. V. 100 V. V.	MILE TO THE	Phone			
Pleas	e circle	Yes or No (If Yes, plea	ase fill in details)				
Yes	No	Is the patient takin	g any medication?				
Yes	No						
Yes	No						
Yes	No	Has the patient ha	d any operations?				
Yes	No	Ever been involved	in a serious accident?				
Yes	No	Have seen a physi-	cian in the last 12 month	s? Why?			
		Female Patients or					
Yes	No						
Yes	No	Is the patient pregi	nant?		2		
Circle	any of	the medical condition	s below that the patient l	has had or currently has.			
Abno	rmal Ble	eding/Hemophilia	Congenital Heart Def	fect Heart Murmur	Nervous Disorders		
Allerg			Diabetes	Hepatitis/Liver Problems	Pneumonia		
Anem			Dizziness		Radiation/Chemotherapy		
Arthri			Epilepsy	High Blood Pressure	Rheumatic Fever		
Asthn	na or Ha	ayfever	Gastrointestinal Disor		Tuberculosis		
	Disorder		Heart Problems	Kidney Problems	Tumor or Cancer		
Are the	ere any n	nedical conditions not lis	sted that you feel we should	be aware of?			
_					DENTAL HISTOR		
Gene	ral Dent	ist		Date of Last Visit			
What	concer	ns you most about yo	ur teeth?				
Yes	No	Is the patient prese	ently in any dental pain?				
Yes	No			to dentistry?			
Yes	No	Has patient ever lo	st or chipped any teeth?				
Yes	No	Have there been a	ny injuries to face, mouth	or teeth?			
Yes	No	Is any part of your	mouth sensitive to temp	erature? Where?			
Yes	No	Is any part of your	mouth sensitive to press	sure? Where?			
Yes	No	Do gums bleed wh	nen brushing?				
Yes	No	Any type of thumb	or tongue habit?				
Yes	No				AM PM		
Yes	No	Has the patient ever seen an orthodontist? If yes, who and where?					
Yes	No	What is the patient	What is the patient's attitude toward receiving orthodontic treatment?				
Yes	No	Has anyone in the	family received orthodor	ntic treatment? first thing in the morning?			
Yes	No	Do teeth and jaws	ever feel uncomfortable	first thing in the morning?			
Yes	No	Experience jaw cli	cking or popping?	g the day?			
Yes	No	Aware of clenching	g or grinding teeth during	the day?			
Yes	No	Experience "tension	on" headaches?	inging in the ears?			
Yes	No	Has the patient ev	er experienced chronic ri	inging in the ears?			
Yes	No	Does the patient n	eed extra help with instri	uctions?			
Yes	No	Is the patient sens	itive or self-conscious at	oout his/her teeth?Mom	D 1		
Yes	No	Height of parents?		Miom	Dad		
Yes	No	Are you aware that	t some appointments wil	I be during school hours?			
appe body sult. there unde ing re my m	arance of parts and Joint dis can be retand to elated properties of the properties o	of the teeth, in the ger and can fail to respond scomfort and root sho some movement of to hat my diagnostic rec rofessionals. I have to or dental history. In ad	neral function of the teeth to treatment. If good or riting are observed in a si eeth and some change a ords and my name may l ruthfully answered all the idition I authorize Dr. Farr	Orthodontics is a service that pro- n, and in general dental health. Te ral hygiene is not practiced, tooth mall percentage of cases. Teeth of fter treatment. I have read and un- be used for educational and prom- above questions and agree to info nsworth to perform a complete ort	eth, gums and jaws are intricate decay and enlarged gums can re- change throughout our lifetime and derstood this paragraph. I also otional purposes including email- form this office of any changes in		
Patier	if over 18	years old	Date				

Parent of Responsible Party _

Relationship to Patient _