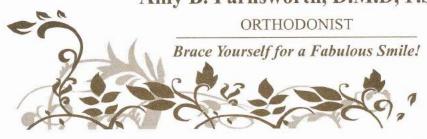
Amy B. Farnsworth, D.M.D, P.S.C



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.

	Patient Inform	nation (Minor)	1			
Date:						
Patient's Name		First	Middle	Ni	ckname	
Address						
Street			City	State	Zip	
Cell Phone Ca	rrier	Pa	tient's Age	_ Birthdate	Sex M F	
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 of	ffice? If yes, t	heir name				
Patient's Dentist			Date of last visit			
	Responsible Par	tv* Informatio	on			
Father		Ly Zillor illawer.				
Last	First		Middle			
Social Security #	Birth Date		Email			
Address						
Street			Oity	State	Zip	
Cell Phone Ca						
Employer	Occup	Occupation Yrs Employed				
Check Appropriate Box: □Sin	gle	□Separated	□Divorced	□Widowed		
Mother	First		Middle			
Social Security #	M.W. 25					
W6			_ Liliali			
AddressStreet			City	State	Zip	
Cell Phone Ca	arrier					
Employer						
*Note: The "Responsible Party" is the individ	dual who will be maki	ing payments. If	there is more that	an one "Responsibl	e Party" (ie	
a divorce case) the parent who signs the co	ntract is ultimately re	esponsible for ma	aking the paymer	nts.		
	Dental Insuran	ce Informatio	<u>n</u>			
Do you have Orthodontic coverage?	Yes □ No					
Insured's Name	Birthdate					
Name of Employer	Name of Ins. Co.					
Social Security #	Ins. Co. Phone #					
Do you have dual coverage? Yes ☐ No						
I,	have r	eceived a copy	of the HIPPA p	rivacy practice.		

MEDICAL HISTORY

Physician							
		Yes or No (If Yes, please fill in details)	_ Phone				
Yes	No	Is the patient taking any medication?					
Yes	No	Is the patient allergic to any medication?					
Yes	No No	History of a major illness?					
Yes	No	Ever been involved in a serious accident?					
Yes	No	Have seen a physician in the last 12 months? W	/hv/2				
165	140	Female Patients only:	VIIV:				
Yes	No	Has menstruation started?					
Yes	No	Is the patient pregnant?					
Circle	any of t	the medical conditions below that the patient has h	nad or currently has.				
Abnor	mal Ble	eding/Hemophilia Congenital Heart Defect	Heart Murmur	Nervous Disorders			
Allergi	es	Diabetes	Hepatitis/Liver Problems	Pneumonia			
Anem	ia	Dizziness		Radiation/Chemotherapy			
Arthrit	1075	Epilepsy	High Blood Pressure	Rheumatic Fever			
Asthm	a or Ha	yfever Gastrointestinal Disorders	HIV/AIDS	Tuberculosis			
	Disorders		Kidney Problems	Tumor or Cancer			
Are the	ere any m	nedical conditions not listed that you feel we should be a	ware of?				
				DENTAL HISTOR			
Gener	al Denti	sts you most about your teeth?	_ Date of Last Visit				
What	concern	s you most about your teeth?					
Yes	No	le the nationt presently in any deptal pain?					
Yes	No	Is the patient presently in any dental pain? Ever experienced any unfavorable reaction to de	entistry?				
Yes	No	Has national ever lost or chipped any teeth?	eritistry:				
Yes	No	Have there been any injuries to face, mouth or t	eeth?				
Yes	No	Has patient ever lost or chipped any teeth?					
Yes	No	Is any part of your mouth sensitive to temperature? Where?					
Yes	No	Do gume bleed when brushing?	vviicio:				
Yes	No	Do gums bleed when brushing?					
Yes	No	Any type of thumb or tongue habit?AM PM					
Yes	No	Has the patient ever seen an orthodontist? If yes, who and where?					
Yes	No	What is the patient's attitude toward receiving orthodontic treatment?					
Yes	No	Has anyone in the family received orthodontic treatment?					
Yes	No	Do teeth and jaws ever feel uncomfortable first thing in the morning?					
Yes	No						
Yes	No	Experience jaw clicking or popping? Aware of clenching or grinding teeth during the	day?	1			
Yes	No						
Yes	No	Experience "tension" headaches? Has the patient ever experienced chronic ringing	g in the ears?				
Yes	No	Does the natient need extra help with instruction	ns?				
Yes	No	Does the patient need extra help with instruction is the patient sensitive or self-conscious about	his/her teeth?				
Yes	No	Height of parents?	Mom	Dad			
Yes	No	Are you aware that some appointments will be	during school hours?				
Benet	its of Or	thodontics: Aesthetics, Health and Function. Orthof the teeth, in the general function of the teeth, and	odontics is a service that prov	oth gume and laws are intricate			
appea	irance o	of the teeth, in the general function of the teeth, and	d in general dental health. Te	desay and enlarged gums can re			
body	parts an	nd can fail to respond to treatment. If good oral hy	giene is not practiced, tooth	becay and enlarged guills can re-			
sult. J	oint also	comfort and root shorting are observed in a small	percentage of cases. Teetin c	dereteed this perserant. Lake			
tnere	can be s	some movement of teeth and some change after the	realment. Thave read and un	ational purposes including amoil			
under	stand th	nat my diagnostic records and my name may be us	sed for educational and profile	otional purposes including email-			
		ofessionals. I have truthfully answered all the above r dental history. In addition I authorize Dr. Farnswo					
ny m				I Sacritio Sydiuditorii			
Patien	if over 18 y	rears old					
Parent		onsible Party	Relationship to Patie	ent			
		(%)					