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.

Patient Information (Minor)

Date: _____

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Cell Phone _____ Carrier _____ Patient'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 office? If yes, their name _____

Patient's Dentist _____ Date of last visit _____

Responsible Party* Information

Father _____
Last First Middle

Social Security # _____ Birth Date _____ Email _____

Address _____
Street City State Zip

Cell Phone _____ Carrier _____ Work Phone _____

Employer _____ Occupation _____ Yrs Employed _____

Check Appropriate Box: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Mother _____
Last First Middle

Social Security # _____ Birth Date _____ Email _____

Address _____
Street City State Zip

Cell Phone _____ Carrier _____ Work Phone _____

Employer _____ Occupation _____ Yrs Employed _____

*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.

Dental Insurance Information

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 received a copy of the HIPPA privacy practice.

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal Bleeding/Hemophilia	Congenital Heart Defect	Heart Murmur	Nervous Disorders
Allergies	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Radiation/Chemotherapy
Arthritis	Epilepsy	High Blood Pressure	Rheumatic Fever
Asthma or Hayfever	Gastrointestinal Disorders	HIV/AIDS	Tuberculosis
Bone Disorders	Heart Problems	Kidney Problems	Tumor or Cancer

Are there any medical conditions not listed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of Last Visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____ 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 Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No 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? _____

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shorting are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understood this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes including emailing related professionals. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition I authorize Dr. Farnsworth to perform a complete orthodontic evaluation.

Patient:_____ Date _____
if over 18 years old

Parent of Responsible Party _____ Relationship to Patient _____