(502) 452-2116
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Amy B. Farnsworth, D.M.D, P.S.C

ORTHODONIST

Beautiful Smiles For Life!

2700 Bardstown Road
Louisville, KY 40205

Adult Patient Information

TODAY'S DATE_____

PATIENT INFORMATION

PATIENT NAME_____DATE OF BIRTH _____ AGE _____ SEX M ☐ F ☐

CELL PHONE # _____ CELL PHONE CARRIER _____ WORK # _____

ADDRESS_____ CITY _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

SOCIAL SECURITY # _____YEARS EMPLOYED _____ S ☐ M ☐ D ☐ W ☐

PATIENT EMAIL _____

DENTIST _____ DATE OF LAST VISIT _____

WHO MAY WE THANK FOR REFERRING YOU? _____

WHO WOULD WE CONTACT IN CASE OF A EMERGENCY? _____ PHONE # _____

ORTHODONTIC INSURANCE INFORMATION

DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE Y ☐ N ☐

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ MEMBER ID # _____ GROUP # _____

RELATIONSHIP TO PATIENT _____ SUBSCRIBER EMPLOYER _____

ORTHODONTIC INSURANCE COMPANY NAME _____

INSURANCE CO. MAILING ADDRESS _____

INSURANCE CO. PHONE # _____

I AUTHORIZE THE PAYMENT AND RELEASE OF ANY INFORMATION TO/FROM THE INSURANCE COMPANY

_____

(Signature)

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No History of a major illness? _____

Yes No Have you 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 Are you presently in any dental pain? _____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you 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 Are you a mouth breather? _____Do you snore?_____Do you have Sleep Apnea?_____

Yes No Have you ever seen an orthodontist? If yes, who and where? _____

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 Have you ever experienced chronic ringing in the ears? _____

Yes No Are you sensitive or self-conscious about your teeth? _____

I confirm all information stated to be correct to the best of my knowledge. I understand it is my responsibility to notify Farnsworth Orthodontics of any changes in my health history.

I have been given the opportunity to read the most current HIPPA rules and regulations and the option of receiving a copy.

I authorize Dr. Farnsworth to perform a complete orthodontic evaluation.

Patient:_____ Date:_____