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

ORTHODONIST

*Beautiful Smiles For Life!*

(502) 452-2116
www.farnsworthortho.com

2700 Bardstown Road
Louisville, KY 40205


## Child Patient Information

**TODAYS DATE**_____

**PATIENT INFORMATION**

PATIENT NAME _____

DATE OF BIRTH _____AGE _____SEX M F

STREET ADDRESS _____

CITY_____STATE_____ZIP_____

CELL PHONE #_____

CELL PHONE CARRIER _____

SCHOOL _____

INTERESTS/ACTIVITIES _____

DATE OF LAST DENTAL CLEANING _____

DENTIST_____PHONE #_____

PHYSICIAN_____PHONE #_____

HOW DID YOU HEAR ABOUT US_____

WHO IS WITH THE CHILD TODAY *(IF APPLICABLE)*

NAME_____RELATIONSHIP_____

ARE THERE OTHER FAMILY MEMBERS IN TREATMENT HERE

_____

IF YES, NAMES/AGES_____

_____

WHO DO WE CONTACT IN CASE OF EMERGENCY

_____PHONE #_____

HAS THE PATIENT SEEN ANOTHER ORTHODONTIST Y☐ N☐

NAME OF THE PERSON RESPONSIBLE FOR FINANCIAL ACCOUNT

_____

DATE OF BIRTH_____

SOCIAL SECURITY #_____

**PRIMARY RESPONSIBLE PARTY**

NAME_____

DATE OF BIRTH_____

SOCIAL SECURITY #_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

CELL PHONE #_____

CELL PHONE CARRIER_____

EMAIL_____

EMPLOYER_____

OCCUPATION_____

**SECONDARY RESPONSIBLE PARTY** *(IF APPLICABLE)*

NAME_____

DATE OF BIRTH_____

SOCIAL SECURITY #_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

CELL PHONE #_____

CELL PHONE CARRIER_____

EMAIL_____

EMPLOYER_____

OCCUPATION_____

## 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, other than baby 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? _____Snore?_____Sleep Apnea?_____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 about braces care? _____
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? _____

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 _____

Parent of Responsible Party _____ Relationship to Patient _____

## 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)*

**If you have secondary insurance, please list all the information requested above for the subscriber on the back of this form.**

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## Signature of Responsible Party/Parent Consent

**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 to my child's health history.**

RESPONSIBLE PARTY/PARENT SIGNATURE _____DATE _____

**PURPOSE OF CONSENT** By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**NOTICE OF PRIVACY PRACTICES** You have the right to read our Notice of Privacy Practices document before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

I, _____ have had full opportunity to read and consider the contents of this consent form and under the Notice of Privacy Practiced document. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment , payment activities and health care operations.

SIGNATURE _____ DATE _____