WELCOME

TO FARLEY ORTHODONTICS

TELL US ABOUT YOURSELF Today's Date_____ Circle: Male or Female

Full Name_____ Prefer to be called_____ Birthdate_____ Age_____
Home Address_____Apt#_____City_____ Zip_____
Cell#_____ Home#/Work#_____ Email Address_____
Employer_____ Occupation_____ SS# (required)_____ DL#_____
Who may we thank for referring you?_____ General Dentist_____ Last visit_____

PERSON FINANCIALLY RESPOSIBLE FOR ACCOUNT

Full Name_____ DOB_____ Relationship to patient_____
Billing Address_____ Apt#_____ City_____ State_____ Zip_____
Employer_____ Occupation_____ SS#(required)_____ DL#_____

SPOUSE INFORMATION

Full Name_____ DOB_____ Email Address_____
Cell#_____ Home#/Work#_____ Is this person an emergency contact? YES or NO

DENTAL INSURANCE Is There Orthodontic Coverage? Y or N (please alert staff if you have secondary insurance)
INS Co._____ INS Co. Address_____
INS phone#_____ Group/Plan#_____ Subscriber_____ Relation to patient_____
Subscriber'sDOB_____ Subscriber's Employer_____Sub. ID#/SS#_____

MEDICAL/DENTAL HISTORY

Has you ever taken phen-Fen?.....Y N
Been evaluated for Orthodontic treatment before?.....Y N
Injuries to face, mouth, or chin?.....Y N
Have adenoids or tonsils been removed?.....Y N
Missing or extra permanent teeth?.....Y N
Pain or tenderness in jaw joint (TMJ/TMD)?.....Y N
Brush teeth daily?.....Y N
Floss teeth daily?.....Y N
Clenching/Grinding?.....Y N
Lip Sucking/Biting?.....Y N
Mouth Breather?.....Y N
Nail biting?.....Y N
Thumb Sucking?.....Y N
Tongue Thrust?.....Y N
Speech Problems?.....Y N
Current Physician_____ Last Visit_____
Your current physical health: GOOD FAIR POOR
Please list all drugs you are currently taking:
_____
Please List all drugs/things you are allergic to:
_____
Latex Y N Metals/Nickel Y N Plastics Y N

Abnormal Bleeding..... Y N
ADD/ADHD.....Y N
Hospitalized.....Y N
Operations.....Y N
Artificial Joints/Valves .....Y N
Asthma.....Y N
Cancer.....Y N
Cong. Heart Defect.....Y N
Convulsions/Epilepsy.....Y N
Rheumatic/Scarlet Fever ...Y N

Diabetes..... Y N
Disabilities.....Y N
Hearing Impairment.....Y N
Heart Murmur.....Y N
Hemophilia.....Y N
Hepatitis.....Y N
HIV+/AIDS.....Y N
Kidney/Liver Problems...Y N
Lupus.....Y N
Tuberculosis.....Y N

Other Medical Issues_____

The following signatures are required before the initial consultation is rendered.

I authorize the dental staff to perform the necessary dental service I may need.
Patient Signature_____ Date_____

I understand that I am responsible for payment of services rendered and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to the office. I authorized the use of this signature on all my insurance submissions, whether manual or electronic.
Patient Signature_____ Date_____