

# Welcome To William K. Farrar Jr., DDS MDS

Please complete, sign and date both sides of this form.

Preferred Name: \_\_\_\_\_ Male:  Female:

Patient's Name: \_\_\_\_\_  
first middle last

**E-mail Address:** \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Phone: \_\_\_\_\_  
home work cell

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

**Whom may we thank for referring you? (please circle one)** \_\_\_\_\_

Family Dentist Friend Newspaper Movie Ad Web-Site

**Family Dentist:** \_\_\_\_\_ **Clinic:** \_\_\_\_\_  
name

Last check-up or cleaning within 6 months? YES NO

Father's Name: \_\_\_\_\_  
first middle last

E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Phone: \_\_\_\_\_  
home work cell

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Orthodontic Insurance: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
first middle last

E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Phone: \_\_\_\_\_  
home work cell

Birth Date: \_\_\_\_\_ Social Security: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Orthodontic Insurance: \_\_\_\_\_

\_\_\_\_\_  
Signature (parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

(over)

Please complete, sign and date both sides of this form.

HEALTH HISTORY

Patient's Name: first middle last

Family Physician: name Clinic:

Last physical within 1 year? YES NO

Allergic Reactions (CIRCLE)

Latex Aspirin Ibuprofen Other:

Frequently Experienced (CIRCLE)

Headaches Fainting Teeth Grinding Vomiting Gagging TMJ Problems Other:

Diagnosed or Treated (CIRCLE)

Arthritis Asthma Seizures Hearing Impaired \*\*Rheumatic Fever Head Trauma Diabetes Anemia Hepatitis \*\*Heart Murmur Teeth Trauma Pregnancy HIV/Aids Blood Pressure \*\*Joint Replacement/Implants

Medications (PLEASE LIST)

- 1. Reason 2. Reason 3. Reason

\*\*Does the patient require antibiotic pre-medication for dental treatment? YES NO

INSURANCE ASSIGNMENT AND RELEASE - I, the undersigned assign directly to William K. Farrar Jr., DDS MDS (West Cobb Orthodontics) all insurance benefits, otherwise payable to me for services rendered. I also hereby authorize William K. Farrar Jr., DDS MDS (West Cobb Orthodontics) to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

FINANCIAL RESPONSIBILITY - I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

In accordance with the federal government HIPAA rules, please sign below to acknowledge you have received our Notice of Privacy Practices; it will in no way affect the care you receive at William K. Farrar Jr., DDS MDS (West Cobb Orthodontics).

Signature (parent or guardian if patient is a minor)

Date

(over)