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: _____

Patient's Employer: _____ Orthodontic Insurance: _____

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

Spouse's Name: _____
first middle last

E-mail Address: _____

Address: _____
street city state zip

Phone: _____
home work cell

Birth Date: _____ Social Security: _____

Spouse's Employer: _____ Orthodontic Insurance: _____

_____ _____
Signature Date

(over)

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

HEALTH HISTORY

Patient's Name: _____
first **middle** **last**

Family Physician: _____ Clinic: _____
name

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 Date

(over)