TOP OF THE HILL
ORTHODONTICS & PEDIATRIC DENTISTRY

PATIENT REGISTRATION

Patient Information

First Name: _____ Last: _____ Middle: _____

Preferred Name: _____ DOB: _____ SSN: _____ Sex: ☐ Male ☐ Female

Home Address: _____ City: _____ State: _____

Zip code: _____ Home Phone: _____

School Name: _____ Zip: _____ Hobbies: _____

Responsible Party

First Name: _____ Last: _____ Middle: _____

DOB: _____ SSN: _____ Sex: ☐ Male ☐ Female

☐ *Check if address is the same as the patient*

Home Address: _____ City: _____ State: _____

Zip code: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext. _____ Email: _____

Primary Insurance Information

Name of Insured: _____

Insured SSN: _____ Insured DOB: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, and Zip: _____

Group #: _____ Insured Member ID: _____ Patient ID (if different): _____

Secondary Insurance Information

Name of Insured: _____

Insured SSN: _____ Insured DOB: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, and Zip: _____

Group #: _____ Insured Member ID: _____ Patient ID (if different): _____

How did you hear about us? :

☐ Facebook ☐ Yelp ☐ Community Fair ☐ Parish Bulletin ☐ Physician/Dentist: _____

☐ Patient: _____ ☐ Other: _____

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Medical History for Orthodontics

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	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Any other medical conditions 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 the patient 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 Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or 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? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Jacob Orozco** to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Patient's Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

_____

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