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: _____

TOP OF THE HILL ORTHODONTICS

Date 8/7/2015

Top of the Hill Dental / Medical History Form

Patient Name: Birth Date: Date Created:

Reason for Today's Visit

Routine Dental Exam	◯ Yes ◯ No	Emergency Treatment	◯ Yes ◯ No	Consultation	◯ Yes ◯ No

Please Indicate if the patient has any of the following problems:

Pain	◯ Yes ◯ No	Discomfort, Clicking or Popping in Jaw	◯ Yes ◯ No	Red, Swollen or Bleeding Gums	◯ Yes ◯ No
Sensitive Tooth/Teeth or Gums	◯ Yes ◯ No	Blisters/Sores in/or Around Mouth	◯ Yes ◯ No	Lost/Broken Filling	◯ Yes ◯ No
Teeth Grinding	◯ Yes ◯ No	Broken/Chipped Tooth	◯ Yes ◯ No	Bad Breath	◯ Yes ◯ No

Other: ◯ Yes ◯ No If yes

Please Indicate Any of the Following Habits:

Thumb/Finger Sucking	◯ Yes ◯ No	Mouth Breathing	◯ Yes ◯ No	Nail Biting	◯ Yes ◯ No	Pacifier	◯ Yes ◯ No

Other Habits? ◯ Yes ◯ No If yes

Physician's Name and Phone Number:

Previous Dentist's Name and Number:

Has the patient ever had a unpleasant dental experience? ◯ Yes ◯ No If yes

Does the patient have a history of a major illness? ◯ Yes ◯ No If yes

Is the patient taking any medications, pills, or ◯ Yes ◯ No If yes

Is the patient on a special diet? ◯ Yes ◯ No If yes

Is the patient allergic to any of the following?

☐ Aspirin	☐ Penicillin and/or Amoxicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Does the patient have, or has the patient had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	ADD/ADHD	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Cerebral Palsy	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Autism / PDD	◯ Yes ◯ No
Hearing Problems	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Birth Defect	◯ Yes ◯ No	Developmental Delay	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Cleft Lip/Palate	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No						

I hereby certify that all information is correct and true to the best of my knowledge and understand it is my responsibility to inform this office of any changes. I agree to the HIPPA regulations as posted. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental treatment can be commenced. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental services. I understand that I am responsible for all charges whether or not covered by insurance.

Signature of Parent or Guardian:

X Date:_____

FOR OFFICE USE ONLY Comments:

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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