Tolar Family Dentistry

PATIENT REGISTRATION AND HEALTH HISTORY **CONFIDENTIAL**

PATIENT NAME:_______________________________ HOME TELEPHONE_________________

ADDRESS:____________________________________ WORK TELEPHONE_________________

CITY:______________STATE________ZIP_________ CELL PHONE________________

PREFERRED CONTACT: HOME/CELL/WORK/EMAIL

EMAIL ADDRESS______________________________

OCCUPATION________________________________

DATE OF BIRTH________________ AGE:_______ GENDER M/F

MARRIED/DIVORCED/WIDOWED/SINGLE SPOUSE/PARTNER'S NAME__________________________

ACCOUNT INFORMATION: PERSON RESPONSIBLE FOR PAYMENT IF NOT PATIENT:

NAME:___________________

ADDRESS:_____________________ CITY:______________STATE_________ZIP_________

TELEPHONE:___________________ RELATIONSHIP TO PATIENT ______________________

EMERGENCY INFORMATION NAME:_____________________________ RELATIONSHIP_______________

PHONE NUMBER_______________________

POLICY HOLDER'S EMPLOYER: ____

PRIMARY DENTAL INSURANCE: **SECONDARY INS:**

NAME OF POLICY HOLDER:_________________ DOB:_______ POLICY HOLDER______________________

INSURANCE COMPANY___________________ INS. COMPANY_______________________

INSURANCE COMPANY ADDRESS___________________ INS. ADDRESS________________________

CITY,STATE,ZIP________________________ CITY/STATE/ZIP_______________________

INSURANCE CO. PHONE___________________ INS. CO PHONE_______________________

SUBSCRIBER#_______________ GRP#_____________ SUBSCRIBER#____________ GRP#________

WHOM MAY WE THANK FOR REFERRING YOU: ____

DENTAL HISTORY: REASON FOR TODAY'S VISIT ____

FORMER DENTIST __________________________ DATE OF LAST XRAYS____________

PLEASE LIST ALL MEDICATIONS____

____

PLEASE LIST ALL KNOWN ALLERGIES____

____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT.

- HEART DISEASE
- HEART ATTACK
- HEART SURGERY
- ANGINA
- HYPERTENSION
- HEART MURMUR
- HEART STENTS OR VALVES
- RHEUMATIC FEVER
- MITRAL VALVE PROLAPSE
- CONGENITAL HEART DISEASE
- CORTIZONE MEDICATION
- ARTIFICIAL JOINTS
- EPILEPSY/SEIZURES
- NEUROLOGICAL DISORDERS
- PSYCHIATRIC CARE
- DENTAL PHOBIA
- VAPING
- ALCOHOL/DRUG USE
- SMOKING/TOBACCO USE
- KIDNEY DISEASE
- LIVER DISEASE
- CROHN'S DISEASE
- ULCERS
- DIABETES
- THYROID PROBLEMS
- GLAUCOMA
- EMPHYSEMA
- TUBERCULOSIS
- DEVELOPMENTAL DISABILITY
- STROKE
- EATING DISORDER
- CANCER
- COLD SORES
- ALLERGIES/HIVES
- HEPATITIS
- ANEMIA
- BLOOD DISEASES
- HIV
- AIDS
- VENEREAL DISEASE
- CHRONIC COUGH
- ASTHMA
- SURGERY
- HOSPITALIZATION
- CHEMOTHERAPY
- RADIATION THERAPY
- PREMED BEFORE DENTAL TREATMENT

PLEASE LIST ANY OTHER CONDITIONS.____

PREGNANT? YES__________MONTHS NO NURSING Y N BIRTH CONTROL PILLS Y N

ACKNOWLEDGEMENT: I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MATTER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

SIGNATURE___________________________________DATE___________________

CONSENT TO TREAT. **The undersigned hereby authorizes the dentist or her designee to take X-rays or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _________________________. I understand that the use of anesthetic agents embodies certain risk. Furthermore, I authorize and consent that the dentist chooses and employs such assistance as deemed appropriate to provide recommended treatment.**

PATIENT:____DATE____

PARENT/GUARDIAN____DATE____

Kim M. Tolar, D.D.S.

Family Dentistry

2502 Napoleon Ave.

New Orleans, La 70115

504-891-1880 Telephone

504-891-1883 Facsimile

Authorization for forwarding periodontal records and radiographs

Dear Doctor ________________________________:

_________________________ has requested that your office forward his or her dental records to the office of Dr. Kim Tolar.

____

Patient's Name (printed)

____

____

Patient's Address

____

Patient's signature

Thank you,

Dr. Kim M. Tolar