Tolar Family Dentistry

PATIENT REGISTRATION AND HEALTH HISTORY ***CONFIDENTIAL***

PATIENT NAME:_____ **HOME TELEPHONE_____**

ADDRESS:_____ **WORK TELEPHONE_____**

CITY:_____STATE:_____ ZIP:_____ **CELL PHONE_____**

PREFERRED CONTACT: HOME/WORK/CELL/EMAIL

EMAIL ADDRESS_____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH_____ Age:_____ Gender M/F

DRIVER'S LICENSE NUMBER_____

MARRIED/DIVORCED/WIDOWED SPOUSE/PARTNER'S NAME_____

ACCOUNT INFORMATION: PERSON RESPONSIBLE FOR PAYMENT IF NOT PATIENT:

NAME:_____ _____ SOCIAL SECURITY:_____

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_____**

SUBCRIBER #_____ GRP #_____ **SUBSCRIBER#_____GRP#_____**

***WHOM MAY WE THANK FOR REFERRING YOU*: _____**

DENTAL HISTORY: **REASON FOR TODAY'S VISIT_____**

FORMER DENTIST_____DATE OF LAST XRAYS_____

1. **HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE PAST TWO YEARS? Y N**
2. **HAVE YOU BEEN UNDER THE ON-GOING CARE OF A PHYSICIAN IN THE PAST TWO YEARS? Y N**
3. **HAVE YOU TAKEN ANY MEDICATIONS REGULARLY IN THE PAST TWO YEARS? Y N**
4. **ARE YOU TAKING MEDICATIONS AT THIS TIME? Y N**
5. **IF SO PLEASE LIST:_____**
6. **PLEASE LIST ALL KNOWN ALLERGIES:_____**
7. **INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT.**

- **CIRCLE Y OR N TO EACH ITEM.**

HEART ATTACK	**Y N**	**ULCERS**	**Y N**	**AIDS**	**Y N**
HEART DISEASE	**Y N**	**DIABETES**	**Y N**	**HIV POSITIVE**	**Y N**
HEART SURGERY	**Y N**	**CHRONIC COUGH**	**Y N**	**ANEMIA**	**Y N**
ANGINA OR CHEST PAIN	**Y N**	**THYROID PROBLEMS**	**Y N**	**CYTOMEGALOVIRUS**	**Y N**
CONGENTIAL HEART DISEASE	**Y N**	**COSMETIC SURGERY**	**Y N**	**COLD SORES/FEVER BLISTERS**	**Y N**
HEART MURMUR	**Y N**	**GLAUCOMA**	**Y N**	**BLOOD TRANSFUSION**	**Y N**
HIGH BLOOD PRESSURE	**Y N**	**EMPHYSEMA**	**Y N**	**HEMOPHILIA/BLOOD DISEASES**	**Y N**
MITRAL VALVE PROLAPSE	**Y N**	**TUBERCULOSIS**	**Y N**	**SICKLE CELL DISEASE**	**Y N**
HEART VALVES OR STINTS	**Y N**	**ASTHMA**	**Y N**	**BRUISE EASILY**	**Y N**
HEART PACEMAKER	**Y N**	**HAY FEVER**	**Y N**	**LIVER DISEASE**	**Y N**
RHEUMATIC FEVER	**Y N**	**ALLERGIES OR HIVES**	**Y N**	**YELLOW JAUNDICE**	**Y N**
ARTHRITIS	**Y N**	**SINUS TROUBLE**	**Y N**	**EPILEPSY OR SEIZURES**	**Y N**
CORTIZONE MEDICINE	**Y N**	**RADIATION THERAPY**	**Y N**	**FAINTING OR DIZZY SPELLS**	**Y N**
SMOKING/TOBACCO USE	**Y N**	**CHEMOTHERAPY**	**Y N**	**NERVOUSNESS/ANXIOUS**	**Y N**
ALCOHOL/DRUG ADDICTION	**Y N**	**HEPATITIS A**	**Y N**	**PSYCHIATRIC CARE**	**Y N**
STROKE	**Y N**	**HEPATITIS B**	**Y N**	**PSYCHOLOGICAL CARE**	**Y N**
ARTIFICIAL JOINTS	**Y N**	**HEPATITIS C**	**Y N**	**DEVELOPMENTALLY DISABLED**	**Y N**
KIDNEY DISEASE	**Y N**	**VENEREAL DISEASE**	**Y N**	**NEUROLOGICAL DISORDER**	**Y N**
MALNUTRITION	**Y N**	**PNEUMONIA**	**Y N**	**CROHN'S DISEASE**	**Y N**
EATING DISORDER	**Y N**	**DRY MOUTH**	**Y N**	**DENTAL PHOBIA**	**Y N**
CANCER	**Y N**	**SWOLLEN ANKLES**	**Y N**	**SHORTNESS OF BREATH**	**Y N**
SPECIAL DIET	**Y N**	**UNEXPLAINED WEIGHT LOSS OR GAIN**	**Y N**		

DO YOU HAVE ANY OTHER CONDTION NOT LISTED? IF SO PLEASE LIST:_____

WOMEN: ARE YOU PREGNANT? YES____MONTHS NO NURSING Y N TAKING BIRTH CONTROL? Y N

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

PATIENT/GUARDIAN SIGNATURE _____DATE _____

CONSENT TO TREATMENT. 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 appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a 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:_____/_____/_____