Leo A. Tokarczyk, D.D.S., P.C.
Specialist in Periodontics
· Oral Medicine
· Dental Implants

(417) 882-2880 • (800) 346-4604
www.springfieldperioimplants.com

PATIENT INFORMATION

Name _____
Last First Middle

Address _____
City State Zip

Home Phone _____ Bus. Phone _____

Cell Phone _____

E-mail Address _____

May we contact you by Text or E-mail? ☐ Text ☐ E-mail ☐ Neither

Whom may we thank for referring you? _____

Birthdate: _____ Sex: M ☐ F ☐ Marital Status: M ☐ S ☐ W ☐ D ☐

Social Security #: _____

Occupation: _____

Employed by: _____ Address: _____

Person Responsible for the Account: (Signature) _____

Relationship to Patient: _____

SSN: _____ Date of Birth: _____

Phone Number: _____

Employed by: _____ Address: _____

For Emergency Contact: _____ Phone #: _____

Your Dentist's Name: _____ City: _____

Primary Medical Doctor's Name: _____

Address: _____

Other Medical Doctors: _____ / _____

Addresses: _____ / _____

Subscriber Name: _____ Date of Birth: _____

Dental Insurance Company: _____

Group #: _____ Sub or Policy # _____ ID # _____

Insurance Coverage Policy Holder: ☐ Self ☐ Spouse ☐ Guardian/Parent

PERMISSION TO RELEASE INFORMATION:

I authorize the dentist to release all info necessary to secure the payment of all benefits. I understand that I am responsible for all charges, whether or not paid by insurance. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise paid to me for services rendered.

I authorize the release of any needed medical or dental information necessary for my care to Leo A. Tokarczyk, D.D.S.

I authorize the use of this signature for all insurance submissions.

Signature: _____ Date: _____
(Patient/Responsible Party)

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Health History

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by marking Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ☐Y ☐N
2. Have there been any changes in your general health in the past year? _____ ☐Y ☐N
3. Date of last physical exam _____
4. Primary Physician's Name _____
   Primary Address _____
5. All other Physicians' Names _____
   Primary Addresses _____
6. Are you now under a physician's care for a particular problem? ☐Y ☐N
   What: _____
7. Have you **ever** had any serious illnesses, operations, or hospitalizations? If so, describe: ☐Y ☐N
8. Height: _____ Weight: _____ Sex: ☐M ☐F
9. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ☐Y ☐N
   - B. Congenital Heart Disease? ☐Y ☐N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ☐Y ☐N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, COPD, Sleep Apnea)? ☐Y ☐N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ☐Y ☐N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ☐Y ☐N
   - G. Phlebitis (blood clot)? ☐Y ☐N
   - H. Liver Disease (Jaundice, Hepatitis)? ☐Y ☐N
   - I. Kidney Disease? ☐Y ☐N
   - J. Diabetes? ☐Y ☐N
   - K. HIV or AIDS? ☐Y ☐N
   - L. Heart stents? ☐Y ☐N
   - M. Hepatitis? ☐Y ☐N
     Type: _____
   - N. Hypothyroidism? ☐Y ☐N
   - O. Hyperthyroidism? ☐Y ☐N
   - P. Arthritis? ☐Y ☐N
   - Q. Stomach Ulcers or Colitis? _____ ☐Y ☐N
   - R. Gastric Reflux/ GERD? ☐Y ☐N
   - S. Frequent Diarrhea/Colitis? ☐Y ☐N
   - T. Glaucoma (open or closed)? ☐Y ☐N
   - U. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Breast, Knee)? ☐Y ☐N
   - V. Cancer? ☐Y ☐N
     Type: _____
   - W. Radiation (X-ray) treatment for Cancer? ☐Y ☐N
   - X. Chemotherapy? ☐Y ☐N
   - Y. Tumor or growth? ☐Y ☐N
   - Z. Any disease, drug, or transplant operation that has depressed your immune system? ☐Y ☐N
10. **ARE YOU USING ANY OF THE FOLLOWING?**
   - A. Antibiotics ☐Y ☐N
   - B. Anticoagulants (Blood Thinners) ☐Y ☐N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐Y ☐N
   - D. High Blood Pressure Medications ☐Y ☐N
   - E. Steroids (Cortizone, etc.) ☐Y ☐N
   - F. Tranquilizers ☐Y ☐N
   - G. Insulin or Oral Anti-Diabetic drugs ☐Y ☐N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug ☐Y ☐N
   - I. Are you taking or have you ever taken Prolia, Bisphosphonates (Fosamax, Actonel, or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers), or any other drugs for bone density? ☐Y ☐N

J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

_____

_____

_____

11. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novacaine, etc.) ☐Y☐N

B. Penicillin or other antibiotics? ☐Y☐N
Name: _____

C. Sedatives, Barbiturates? ☐Y☐N
Name: _____

D. Aspirin or Ibuprofen? ☐Y☐N

E. Codeine or other pain medications? ☐Y☐N

F. Latex or Rubber Products? ☐Y☐N

G. Any anaphylaxis reactions? ☐Y☐N

H. Other allergies, or reactions? Please list: _____

_____

_____

12. Do you smoke, chew, or use any of the following: tobacco, marijuana, cannabis, vaping? How much per day? ☐Y☐N

_____

13. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ☐Y☐N

14. Have you had any serious problems associated with any previous dental treatment? ☐Y☐N

15. Have you or an immediate family member had any problem associated with intravenous anesthesia? ☐Y☐N

16. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? ☐Y☐N
What: _____

17. **FOR WOMEN ONLY:**

A. Are you pregnant, or **is there any chance** you might be pregnant? ☐Y☐N

B. Are you nursing? ☐Y☐N

C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I grant authority to Dr. Tokarczyk to perform treatment involving administration of local anesthetic medications, and dental procedures that may be necessary.

I authorize the release of any needed medical or dental information necessary for my care to Leo A. Tokarczyk, D.D.S.

I understand the importance of a fully accurate Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor and will promptly report any changes.

_____ _____ _____

Date | Signature of Person Completing Health History | Doctor's Initials

_____

Print Name

do not sign below line unless this is an update

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

I grant authority to Dr. Tokarczyk to perform treatment involving the administration of local anesthetic, medications, and dental procedures that may be necessary.

_____ _____ _____ _____

Date | Exceptions or Changes | Patient's Signature | Doctor's Initials

DENTAL HISTORY

Patient's Name _____ Current Dentist _____

Address _____

__ 1. What brings you here? _____

Check Yes or No

☐ Yes ☐ No 2. Have you been having problems in a specific area of your mouth? Where? _____
What? _____

☐ Yes ☐ No 3. Has fear of discomfort kept you from regular dental visits?

☐ Yes ☐ No 4. Do your gums bleed frequently?

☐ Yes ☐ No 5. Do you floss daily?

☐ Yes ☐ No 6. Are you troubled with bad breath?

☐ Yes ☐ No 7. Do you have sensitive teeth? When? _____

☐ Yes ☐ No 8. Do you have difficulty in chewing your food? Why? _____

☐ Yes ☐ No 9. Have you noticed any looseness of your teeth? Which? _____

☐ Yes ☐ No 10. Have any of your teeth changed in position? Which? _____

☐ Yes ☐ No 11. Do you clench or grind your teeth? When? _____

☐ Yes ☐ No 12. Do your jaws "pop" or "lock" when opening your mouth? Any pain? _____

☐ Yes ☐ No 13. Do you have severe nasal congestion?

☐ Yes ☐ No 14. Do you have severe sinus disease?

☐ Yes ☐ No 15. Do you have sore jaw muscles? When? _____

☐ Yes ☐ No 16. Have you ever had:

Injury to face, jaws or teeth? How? _____

Oral surgery? Type? _____

Orthodontic treatment? When? _____

Periodontal (gum) surgery? When? _____

☐ Yes ☐ No 17. How do you feel about the appearance of your teeth? _____

☐ Yes ☐ No 18. How do you feel about the possibility of losing your teeth? _____

☐ Yes ☐ No 19. Is there anything else we should know? _____

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Your Medication List

Name: _____

Date: ___ ___ ___

Thank you for taking the time to fill out your forms. So we can give you the best of care, please list below all medications, prescriptions and over the counter medicine, why you take them and the prescribing Doctor. Also list all vitamins, minerals and supplements that you are taking.

Please also list all your doctors (medical and dental) with phone numbers. It helps us greatly in expediting your care.

Prescription Medication	Dose	Reason	Prescribing Doctor

Over The Counter Medication	Dose	Reason	Frequency

Physicians Name	Adress	Phone Number

Thank you