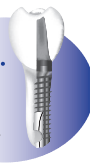
Leo A. Tokarczyk, D.D.S., P.C.
Specialist in Periodontics
• *Oral Medicine*
• *Dental Implants*



PATIENT INFORMATION

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

Name ____
Last First Middle

Address ____
City State Zip

Home Phone______________________ Bus. Phone______________________

E-mail Address ____

❑ May we contact you by E-mail? ❑ Yes ❑ No

Birthdate:______________ Sex: M F Marital Status: M S W D

Social Security #:______________________

Employed by:______________________ Address: ______________________

Responsible Party: (Signature) ____

Spouse/Parent Name: ____

Address:____

Employed by:______________________ Address: ______________________

For Emergency Contact:______________________ Phone #: ______________________

Your Dentist's Name:______________________ City: ______________________

Primary Medical Doctor's Name: ____

Address:____

Other Medical Doctors:______________________/ ______________________

Addresses:______________________/ ______________________

Referred Today By:____

Dental Insurance Company:____

Group #:______________ Sub or Policy #______________ ID # ______________

Insurance Coverage Policy Holder:______Self ______ Spouse

PERMISSION TO RELEASE INFORMATION:

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

Signature:______________________________ Date: ______________________

MEDICAL HISTORY

Leo A. Tokarczyk, D.D.S.

Patient's Name ______________________________ Current Physician ______________________________
Address ______________________________
MD Phone ______________________________

Circle Yes or No

Yes No 1. Have there been any major changes in your health this year? ______________________________

Yes No 2. Are you receiving any active treatment by a physician? For what? ______________________________

Yes No 3. Are you taking any medications? List: ______________________________

Yes No 4. Are you currently taking Birth Control pills or Estrogen Supplement?

Yes No 5. Have you been hospitalized in the last 5 years? What for? ______________________________

Yes No 6. Have you ever been seriously ill? When? ______________________________
What? ______________________________

Yes No 7. Have you been treated for a growth or tumor? Location and type? ______________________________

Yes No 8. Do you bleed uncontrollably?

Yes No 9. Have you ever had an unusual reaction to a dental anesthetic, general anesthetic, Aspirin, Codeine, Demerol, Penicillin, Sulfa, Talwin, Tetracycline, Tylenol, Valium, OTHER? ______________________________

Yes No 10. Have you ever been told not to take any local anesthetics? Name ______________________________

Yes No 11. Have you ever had painful or swollen joints (especially ankles)? Cause ______________________________

Yes No 12. Do you have chest pain at rest?

Yes No 13. Do you have shortness of breath at rest?

Yes No 14. Do you have a pacemaker?

Yes No 15. Are you prone to motion sickness?

16. Have you ever had any of the following?

- ❒ Chemotherapy
- ❒ Radiation Therapy
- ❒ Rheumatic fever
- ❒ Rheumatic heart disease
- ❒ Back problems
- ❒ Spinal surgery
- ❒ Arthritis
- ❒ Heart trouble
- ❒ Heart attack
- ❒ Alcoholism
- ❒ Asthma
- ❒ Hepatitis
- ❒ Jaundice
- ❒ Drug addiction
- ❒ Bad nose bleeds
- ❒ Kidney damage
- ❒ Prosthetic implant
- ❒ Artificial joint
- ❒ Venereal disease
- ❒ HIV/AIDS
- ❒ Artificial heart valve
- ❒ Hives/skin rash
- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Tuberculosis
- ❒ Anemia
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Frequent headaches/dizziness
- ❒ Fainting spells
- ❒ Stroke
- ❒ Emphysema
- ❒ Bronchitis
- ❒ Persistent cough/sore throat
- ❒ Ulcer
- ❒ Liver damage
- ❒ Colitis/frequent diarrhea
- ❒ Glaucoma
- ❒ Phlebitis
- ❒ Skin disease
- ❒ Nervous breakdown
- ❒ Heart murmur

Yes No 17. (Women) are you pregnant?

Yes No 18. Have you recently had a rapid unexplainable weight change?

Yes No 19. Does climbing a flight of stairs produce chest pain?

Yes No 20. Does climbing a flight of stairs produce shortness of breath?

AUTHORIZATION: To the best of my knowledge, the above health history is accurate and complete. I grant authority to the dentist to perform treatment involving administration of local anesthetic, medication, 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.

Signature: ______________________________ Date: ______________________________

DENTAL HISTORY

Patient's Name ______________________________ Current Dentist ______________________________

Address ______________________________

Circle Yes or No

Yes No 1. Have you been having problems in a specific area of your mouth? Where? ____________
What? ______________________________

Yes No 2. Has fear of discomfort kept you from regular dental visits?

Yes No 3. Do your gums bleed frequently?

Yes No 4. Do you floss daily?

Yes No 5. Are you troubled with bad breath?

Yes No 6. Do you smoke? ____________ packs per day

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 sinus congestion?

Yes No 14. Do you have sore jaw muscles? When? ______________________________

Yes No 15. Have you ever had:

Injury to face, jaws or teeth? How? ______________________________

Oral surgery? Type? ______________________________

Orthodontic treatment? When? ______________________________

Periodontal (gum) surgery? When? ______________________________

Yes No 15. Do you have any disease, condition or problem not listed above that I should know about?

____

____

Yes No 16. How do you feel about the possibility of losing your teeth? ______________________

____

____

Yes No 17. Is there anything else we should know? ______________________________

____

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4777 South National • Springfield, MO 65810
P 417-882-2880 • F 417-882-1440
www.springfieldperioimplants.com

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	Address	Phone Number

Thank you