OZARK MOUNTAIN
PERIODONTICS
Board Certified in Periodontology
and Dental Implant Surgery

1355-D East Bradford Parkway
Springfield, MO 65804
417-882-4600 or 800-770-4602
Fax: 417-882-1677
wesaveteeth@bradburks.com
www.SpringfieldPeriodontist.com

Patient Registration

Answers to the following questions are for our records only. They will be considered confidential and will become part of your permanent dental record. Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

Last Name _____ First Name _____ Middle Initial ____

What name would you like to be called in our office? _____

Mailing Address _____

City _____ State _____ Zip _____

Home Telephone # _____ Cell Phone # _____

Business Telephone # _____ *Please circle best contact number*

Email Address _____ Confirm appointments by: email _____ text _____

Place of Employment/Occupation _____

Date of Birth _____ Age _____ Social Security # _____

If married, spouse's name _____ Spouse's Telephone # _____

If patient is a minor, parents' name(s) _____ Parent's Telephone # _____

Whom should we notify in case of an emergency?_____ Telephone #_____

Physician's Name _____ Telephone # _____

_____ _____

Dentist's Name _____ How long have you seen your present dentist?_____

Whom may we thank for referring you? _____

If you have Dental Insurance please provide us with your insurance card. The following information is needed to properly file your dental insurance claim:

Subscriber's Full Name _____

Subscriber's Place of Employment _____

Subscriber's Social Security Number _____

Subscriber's Date of Birth _____

Dental Insurance Company Name _____

Claims Address _____

Phone # _____ Group # _____ Subscriber ID #_____

MEDICAL HISTORY

Height _____ Weight _____

1. Have you been seen by a physician within the last two years? Yes No
   If yes, for what problem? _____
2. Have you been hospitalized or had a serious illness within the last 5 years? Yes No
   If yes, what? _____
   _____
3. Have you ever had problems with Anesthetics or Anesthesia? Yes No
   If yes, what? _____
4. Have you ever had an operation? Yes No
   If yes, for what problem? _____
   Any complications? (please describe) _____
5. Are you taking any drug or medications? (please include over-the-counter or unprescribed medications) Yes No
   _____
   _____
   _____
   _____
6. Do you currently, or have you ever, smoked, vaped or chewed tobacco? Yes No
   If yes, how long? _____
   How many packs/cans per day? _____
7. Are you allergic or have you reacted adversely to any drugs or medical supplies? Yes No
   If yes, what? _____

Heart Murmur.....Yes.....No
Mitral Valve Prolapse.....Yes.....No
Heart Pacemaker.....Yes.....No
Heart Disease or Attack.....Yes.....No
Heart Arrhythmia.....Yes.....No
Artificial Heart Valve.....Yes.....No
Congenital Heart Lesions.....Yes.....No
Angina Pectoris.....Yes.....No
High Blood Pressure.....Yes.....No
Rheumatoid or Psoriatic Arthritis.....Yes.....No
Stroke.....Yes.....No
Tuberculosis.....Yes.....No
Bacterial Endocarditis (SBE).....Yes.....No
Artificial Joint.....Yes.....No
Hemophilia.....Yes.....No
Hepatitis A B C (circle one).....Yes.....No
HIV Positive.....Yes.....No
Bleeding Problems.....Yes.....No

Glaucoma.....Yes.....No
Thyroid Disease.....Yes.....No
Congestive Heart Failure.....Yes.....No
Breathing or Respiratory Problems.....Yes.....No
Sinus Trouble.....Yes.....No
Asthma.....Yes.....No
Arthritis.....Yes.....No
Anemia.....Yes.....No
Ulcers.....Yes.....No
Liver Disease.....Yes.....No
Kidney Disease.....Yes.....No
Osteoporosis.....Yes.....No
Diabetes.....Yes.....No
Cancer.....Yes.....No
Radiation or Chemotherapy.....Yes.....No
Epilepsy or Seizures.....Yes.....No
Psychiatric Treatment.....Yes.....No
Drug or Alcohol Addiction.....Yes.....No
Are you pregnant or nursing?.....Yes.....No

Patient, Parent or Guardian's Signature _____ **Date** _____

OFFICE USE ONLY:

Blood Pressure _____ Respiration _____

Pulse _____ Oxygen Saturation _____

ASA _____

Aiway Mallampti Class (Circle) I II III IV