Brad R. Burks
DMD, PC
Practice Limited to Periodontics

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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 # ____________________

Email Address ____________________ Confirm appointments by email? __ Yes __ No

Place of Employment/Occupation ____________________

Date of Birth ____________________ Age ________ Social Security # ____________________

If married, spouse's name ____________________ Spouse's Business Telephone # __________

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

Physicians' Name(s) ____________________ Telephone # ____________________

____________________ ____________________

____________________ ____________________

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

Dentist's Name ____________________ Telephone # ____________________

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 __________

Insurance Name ____________________ Group Number ____________________

Insurance Claim Address ____________________

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) If yes, what? Yes No
   ____

6. Do you smoke or chew tobacco? How many packs per day? ________________ Yes No

7. Are you allergic or have you reacted adversely to any drugs or medical supplies? Yes No
   If yes, what? ____

8. Indicate any of the following which you have had or have at present:

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
Rheumatic Fever....................Yes.....No
Stroke....................Yes.....No
Tuberculosis....................Yes.....No
Bacterial Endocarditis (SBE)....................Yes.....No
Artificial Joint....................Yes.....No
Blood Transfusion....................Yes.....No
Hemophilia....................Yes.....No
Hepatitis A B C (circle one)....................Yes.....No
HIV Positive....................Yes.....No
Sickle Cell Disease....................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 Trouble . . . . 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 ______________________________

Medical Consultant:

Needed____________________ Sent ____________________ Received ____________________