

Thank you for contacting our office, and welcome to our practice. Please complete the attached three-page registration form and bring it with you to your appointment.*

In addition, please follow these guidelines in preparation for your visit:

- 1). Please bring your referral information and x-rays, if any, from your restorative dentist.
- 2). Eat breakfast or lunch before your appointment to ensure a normal blood glucose level.
- 3). Arrive 10 minutes early to complete a few additional forms. Bring a complete list of all medications and dosages with you.
- 4). Take all of your routine medications, including aspirin therapy, if applicable. However, do not take medication for discomfort (i.e., ibuprofen, Advil, Motrin, Aleve, etc.) prior to the first visit because it may mask symptoms and hinder diagnosis.
- 5). If you require prophylactic antibiotics before dental visits for a prosthetic heart valve or orthopedic prosthesis (artificial hip, knee, elbow, etc.), please call our office for instructions. If you've already discussed this with us, you do not need to call again.
- 6). Please let us know if you take Coumadin (warfarin sodium), so we can contact your physician in advance to receive your current INR readings.
- 7). Our office hours are from 8:30 am until 5:00 pm, Monday-Friday. Occasionally, last minute emergency patients can delay our schedule, so please allow a little extra time for your appointment. We value your time and will try to keep you updated when delays occur.
- 8). All patients under the age of 18 must be accompanied on each visit by their parent or legal guardian.
- 9). Please explore our website at www.endocc.com to learn more.
- 10). Insurance: Endodontic fees are based on the complexity of the procedures. We will make every effort to help you get reimbursed by your insurance carrier, so please bring your dental and medical insurance information with you. Dr. Mischenko participates with a select group of insurance carriers. We welcome any questions you may have about payments and insurance benefits.

We look forward to being of service to you. If you have any questions, please don't hesitate to call us.

*Completion of these forms does not constitute the establishment of a doctor-patient relationship.

Patient Registration and Health History Form

Please use black pen only. On future visits please be sure to update your medical history.

Patient Information

Mr. Ms. Mrs. Dr. First name _____ M. I. _____ Last name _____

Sex: M F Date of birth: / / Email: _____

Street: _____

City: _____ State: _____ Zip: _____

Phones: Home: _____ Business: _____ Cell: _____

General dentist: _____ Referred by: _____
(First and last name) (Please write "same" if referred by general dentist)

Other dental specialists you see (i.e., periodontist): _____

Physician: _____ Phone: _____

Emergency Contact

In case of emergency contact: _____ Spouse Father Mother Other

Phones: Home: _____ Business: _____ Cell: _____

Reason for Visit

What is the reason for your visit today?

How long have you had this problem?

What are your symptoms?

Medical History

Please answer the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

Y N Are you in good health? Height: _____ Weight: _____

Y N Are you under the care of a physician? Date of last physical examination: _____

Y N Have you had any illness, operation, or been hospitalized in the past five years? _____

Y N <input type="checkbox"/> <input type="checkbox"/> Prosthetic joint implant _____ <input type="checkbox"/> <input type="checkbox"/> Heart valve replacement or vascular graft <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves/prosthetic valve <input type="checkbox"/> <input type="checkbox"/> Heart attack(s)/myocardial infarction (MI) <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat/tachycardia <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse/heart murmur <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever/Rheumatic Heart Disease <input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> <input type="checkbox"/> Heart surgery/bypass surgery <input type="checkbox"/> <input type="checkbox"/> Stroke/Transient Ischemic Attack (TIA) <input type="checkbox"/> <input type="checkbox"/> Convulsions/epilepsy <input type="checkbox"/> <input type="checkbox"/> Bronchitis/chronic cough <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> COPD <input type="checkbox"/> <input type="checkbox"/> Respiratory problems <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Emphysema	Y N <input type="checkbox"/> <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> <input type="checkbox"/> Smoking/chewing tobacco <input type="checkbox"/> <input type="checkbox"/> Blood transfusion <input type="checkbox"/> <input type="checkbox"/> Blood disorder/anemia <input type="checkbox"/> <input type="checkbox"/> Bruise easily <input type="checkbox"/> <input type="checkbox"/> A history of drug abuse <input type="checkbox"/> <input type="checkbox"/> Eye disease/glaucoma <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> Hepatitis/jaundice/liver disease <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS/STD <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble <input type="checkbox"/> <input type="checkbox"/> Fainting spells <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Swollen ankles/joint disease <input type="checkbox"/> <input type="checkbox"/> Low blood sugar <input type="checkbox"/> <input type="checkbox"/> Kidney trouble <input type="checkbox"/> <input type="checkbox"/> Are you on dialysis	Y N <input type="checkbox"/> <input type="checkbox"/> Bisphosphonates: Fosamax, Acetonel, Aredia, Boniva, Zometa, and Didronel <input type="checkbox"/> <input type="checkbox"/> Arthritis/joint disease <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers/GERD <input type="checkbox"/> <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> <input type="checkbox"/> Contagious diseases <input type="checkbox"/> <input type="checkbox"/> Delay in healing <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Tumor/ growth <input type="checkbox"/> <input type="checkbox"/> Breast surgery of any type <input type="checkbox"/> <input type="checkbox"/> Radiation/chemotherapy/cancer <input type="checkbox"/> <input type="checkbox"/> Are you on a diet <input type="checkbox"/> <input type="checkbox"/> Immune system problems <input type="checkbox"/> <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> <input type="checkbox"/> History of alcohol abuse <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> <input type="checkbox"/> Mental health problems <input type="checkbox"/> Other _____
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Medications

Are you taking any of the following medications (please circle)?

<i>Blood thinner:</i> Coumadin (Warfarin)	Alpha-adrenergic blockers, phenoxybenzamine, prazosin
Ephedra, yohimbe <i>herbals</i>	Levodopa, thyroid hormones: levothyroxine, liothyronine
<i>Antipsychotic,</i> haloperidol, thioridazine	Beta-adrenergic blockers, nonselective, <i>antiarrhythmic agent</i> , <i>Class II</i> , dorzolamide/timolol, levobunolol, metipranolol, nadolol, nadolol/bendroflumethiazide, propranolol, sotalol, timolol
Catechol-O- methyltransferase inhibitor	CNS stimulants: amphetamine, methylphenidate, ergot derivatives: dihydroergotamine, methysergide
	Digitalis: digoxin, digitoxin
Cocaine	Methyldopa, adrenergic neuronal blocking drugs: guanadrel, guanethidine, reserpine
MAO <i>antidepressant</i>	Tricyclic <i>antidepressants</i> amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine Maprotiline

Please list all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies

Y N <input type="checkbox"/> <input type="checkbox"/> Penicillin, Amoxicillin, Augmentin <input type="checkbox"/> <input type="checkbox"/> Aspirin, Advil, Motrin, ibuprofen <input type="checkbox"/> <input type="checkbox"/> Sulfa/sulfites <input type="checkbox"/> <input type="checkbox"/> Other antibiotics Other _____	Y N <input type="checkbox"/> <input type="checkbox"/> Valium or other tranquilizers <input type="checkbox"/> <input type="checkbox"/> Local anesthetic (novocaine, adrenalin) <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> Latex Other _____
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Women

- Y** **N** Are you pregnant? If yes, estimated delivery date: _____
- Y** **N** Is there a possibility of pregnancy?
- Y** **N** Are you nursing?
- Y** **N** Are you taking birth control pills? (Antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

All Patients

- Y** **N** Have you been told by your physician to take antibiotics prior to dental treatment?
- Y** **N** Is there any health condition about which the doctor should know?
- Y** **N** Do you wish to speak to the doctor privately about anything?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

Patient Signature: X
(Parent or Guardian if minor)

Date: X

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Patient Signature: X
(Parent or Guardian if minor)

Date: X

Doctor: **X**

Witness: **X**

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Martin D. Levin and Martin D. Levin, DMD, LLC will use and disclose your personal health information to treat you and to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. You may refuse to sign this acknowledgement.

Patient Signature: X
(Parent or Guardian if minor)

Date: X