MARTIN D. LEVIN, DMD
ANASTASIA MISCHENKO, DDS, MS
GEORGE JONG, DDS

Practice Limited to Endodontics

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. DO NOT drink caffeinated drinks, like regular coffee.

3) Arrive 10 minutes e·arly 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 8:30am until 5:00pm, 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 tohelp you get reimbursed by your insurance carrier, so please bring your dental and medical insurance information with you. Drs. Mischenko and Jong participate 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.

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Anastasia Mischenko, DDS, MS
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Bethesda-Chevy Chase Root Canal Specialists, LLC

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

Medications

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

Blood thinner: Coumadin (Warfarin)	Alpha-adrenergic blockers, phenoxybenzamine, prazosin
Ephedra, yohimbe *herbals*	Levodopa, thyroid hormones: levothyroxine, liothyronine
Antipsychotic, haloperidol, thioridazine	Beta-adrenergic blockers, nonselective, *antiarrhythmic agent, Class II*, 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 *antidepressant*	Tricyclic *antidepressants* amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine Maprotiline

Please list all medications you are currently taking:

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

Allergies

Y N Penicillin, Amoxicillin, Augmentin Y N Aspirin, Advil, Motrin, ibuprofen Y N Sulfa/sulfites Y N Other antibiotics Other_____	Y N Valium or other tranquilizers Y N Local anesthetic (novocaine, adrenalin) Y N Codeine or other narcotics Y N Latex Other_____

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 which the doctor should know about?
Y N Do you wish to speak to the doctor privately about anything?

Consent

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 _____ **Date:** X _____
(Parent or Guardian if minor)

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_____ **Date:** X _____
(Parent or Guardian if minor)

Doctor: X _____ Witness: X _____

Acknowledgement of Receipt of Notice of Privacy Practices

Drs. Martin D. Levin, Anastasia Mischenko, George Jong and Bethesda-Chevy Chase Root Canal Specialists, LLC will only 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.

Patient Signature: X _____ **Date:** X _____
(Parent or Guardian if minor)