ENDODONTICS
OF MICHIANA PC
Bradley R. Swanson D.D.S., M.S.D.

PATIENT REGISTRATION

Patient Information

Check: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Rev Sex: ❑ Male ❑ Female

Patient's Name _____ / _____ / _____
First Last Middle

Address _____ / _____ / ____ / _____
Street City State Zip

Date of Birth _____ Social Security No. ___-___-___ Employer _____

HmTel: (___) _____ WkTel: (___) _____ Mobile: (___) _____

Person to Contact in Case of Emergency _____ Phone: (___) _____

Family Dentist: _____ Personal Physician _____ Phone: (___) _____

Whom may we thank for referring you? ❑ Family Dentist ❑ Other _____ ❑ No Referral

Person Responsible for Account/Payment _____ Same Address? Yes❑ No❑

Dental Insurance Information

Name of Insured _____ ❑ Male ❑ Female

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

SS# OR Subscriber ID _____ Date of Birth _____ Phone (___) _____

Insurance Address _____ / _____ / ____ / _____
Street City State Zip

Employer _____ Insurance Co. _____

Ins. Group No. _____ Insurance Co. Phone (___) _____

Please inform us if you have *SECONDARY INSURANCE COVERAGE.*

Method Of Payment ❑ Cash ❑ Check ❑ Credit Card ❑ Other _____

Comments

_____

_____

_____

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ALLERGIES *circle all that apply* penicillin latex local anesthetic aspirin valium sulfa ibuprofen codeine clindamycin Other: _____

Women Taking birth control pills? ❑ yes ❑ no Are you nursing? ❑ yes ❑ no Are you pregnant? ❑ yes ❑ no

Medical History *Check all that apply*

Cardiovascular (heart)
- High Blood Pressure ❑
- Heart Attack ❑
  - If so, when? _____
- Angina/Chest Pain ❑
  - If so, when last? _____
- Take Daily Aspirin ❑
- Coumadin/Blood Thinners ❑
- Heart Murmur ❑
- Mitral Valve Prolapse ❑
- Rheumatic Fever ❑
- Congenital Heart Defect ❑
- Irregular Heart Beat ❑
- Heart Pacemaker ❑
- Heart Surgery ❑
  - If so, when? _____
- Other Heart Problems ❑
  - What, _____
  - When, _____

Nerves & Sensory
- Severe Headaches ❑
- Fainting/Dizzy Spells ❑
- Epilepsy/Seizures ❑
- Nervousness ❑
- Other ❑

Respiratory (breathing)
- Sinus Problems ❑
- Allergies or Hives ❑
- Asthma ❑
  - Use Inhaler? ❑
  - How often? _____
- Tuberculosis ❑

Endocrine (hormonal)
- Diabetes ❑
  - Take insulin? ❑
- Thyroid Disease ❑

Gastrointestinal (stomach)
- Ulcers ❑
- Hepatitis ❑
  - When? _____
  - If so, type? _____
- Liver Disease ❑
- Cirrhosis ❑

Hematologic (blood)
- Stroke ❑
  - If so, when? _____
- Anemia ❑
- Prolonged Bleeding ❑
- Leukemia ❑
- HIV/AIDS Positive ❑

Urinary
- Urinate frequently? ❑
- Kidney problem ❑

Have you been instructed to premedicate with antibiotics prior to all dental treatment for any health related conditions (such as MVP, Artificial Joints, Rheumatic Fever, Murmurs etc…..) ❑

Dermal/Musculoskeletal
- Sore Jaw Muscles/Joints ❑
- Arthritis ❑
- Artificial Joint ❑
- Mouth Ulcers/Sores ❑

Other Conditions
- Enlarged Node/Gland ❑
- Use Tobacco ❑
- Use Alcohol ❑
- Cancer/Chemo/Radiat ❑

Others Not Listed

_____

_____

_____

MEDICATIONS _____

_____

_____

Dental Information *Circle all that apply*

Difficult to Numb Previous Traumatic Experience
Recent Oral Surgery Tooth Sensitivity to Cold/Hot Orthodontic Therapy Headaches/Neck Pain
Recent Swelling Trauma to teeth current/past Recent Dental Work Anxious

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

I understand that the information I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, including x-rays. I understand that treatment is no guarantee of success and that complications, which may result in tooth loss or necessitate further treatment, may occur. I also understand that I am to return to my dentist for a permanent restoration following the completion of root canal therapy.

PRINTED NAME: _____ **Birth Date:** _____

SIGNATURE: _____ **Date:** _____