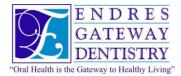


Dental History

Please check any of the following problems that apply to	Reason for leaving previous dentist		
you.			
Sensitivity (hot, cold, biting, sweets)			
Where? □UR □UL □LR □LL			
\Box Headaches, earaches, neck pain	If you could whiten your teeth for a cost anyone could		
□Jaw joint pain	afford, would you do it?		
□Teeth or fillings breaking			
\Box Grinding or clenching teeth	□Yes □No		
\Box Bleeding, swollen, or irritated gums			
\Box Loose, tipped, or shifting teeth	If I could change my smile, I would:		
\Box Bad breath/taste in mouth	Make them whiter		
□Drinks soft drinks	☐ Make them straighter		
□Drinks coffee/tea	Close spaces		
	Replace black fillings with tooth colored		
Do you have or have you had any of the following?	Repair chipped teeth		
Dentures	□ Replace missing teeth		
Partial Dentures	\Box Replace old crowns that don't match		
□Braces/Invisalign	\Box Have a smile makeover		
Periodontal (Gum) Treatments			
□Oral Surgery	Are you interested in facial esthetics such as		
□Night Guard or Retainer	Botox or Fillers?		
□Sleep Apnea Appliance	□Yes □No		
Please share the following dates:	On a coale of 1, 10, with 10 being the highest rating:		
Last cleaning	On a scale of 1-10, with 10 being the highest rating: How important is dental health to you?		
	1 2 3 4 5 6 7 8 9 10		
Last oral cancer screening	Where would you rate your current dental health?		
	1 2 3 4 5 6 7 8 9 10		
Last complete set of x-rays	Where would you like your dental health to be?		
Name/Phone number/Address of previous dentist	1 2 3 4 5 6 7 8 9 10		
	What is the most important thing to you about your visit today?		
City State	What is the most important thing to you about the future your smile?		
Phone Number			

future of



Medical History

Are you under the care of a physician?		S YES	🗆 NO	If Yes
Have you ever been hospitalized or had a	major surgery?	YES	🗆 NO	If Yes
Have you ever had a serious head or neck	injury?	🗆 YES	🗆 NO	If Yes
Do you use tobacco, vape, or marijuana?		□ YES	🗆 NO	If Yes
Have you ever had a joint replacement?		□ YES	🗆 NO	If Yes
Are you currently or have taken blood thi	nners			
such as Warfarin, Xaralto, or Coumac	lin?	🗆 YES	🗆 NO	If Yes
Do you take or have you taken Fosamax,	Bonivia, Actonel,			
or any other medication containing b	isphosphonates?	□ YES	🗆 NO	If Yes
Have you ever been exposed to Tubercule	osis?	□ YES	🗆 NO	If Yes
Are you on a special diet?		□ YES	🗆 NO	If Yes
Do you used controlled substances?		□ YES	□ NO	If Yes
What medications are you currently takin	ıg?			
Women:				
Pregnant	Nursing		🗆 Taking	oral contraceptives

JSulfa Drugs Other are you had or do you currently have any of the following conditions? ONLY CHECK IF YES JAIDS/HIV Rheumatism JAIDS/HIV Rheumatism JAIDS/HIV Scarlet Fever JAIDS/HIV Scarlet Fever Janaphylaxis Schingles Janaphylaxis Schingles Janaphylaxis Singles Jangina Sinus Trouble JArtificial Heart Valve Stomach/Intestinal Issues JArtificial Heart Valve Storach/Intestinal Issues JArtificial Joint Stroke Justina Cancer Juster Problems Blood Transfusion Jirregular Heartbeat Chemotherapy Jueukemia Cold Sores/Fever Blisters Jueukemia Congenital Heart Disorder Juber Oisease Heart Attack/Failure Thybrid Disease Convulsions Jueukemia Controlsone Medicine Tonsilitis Consone Medicine Thuberculosis Diabetes Jueukemia Cortisone Medicine Tonsilitis Estaily Winded Jonsilitis Drug Addictio							
JSulfa Drugs Other	Are you allergic to	o any of the followin	g?				
Averyou had or do you currently have any of the following conditions? ONLY CHECK IF YES AIDS/HIV Rheumatism Frequent Headaches Alzheimer's disease Scarlet Fever Low Blood Pressure Anaphylaxis Shingles Lung Disease Anemia Sickle Cell Disease Mitral Valve Prolapse Anemia Sinus Trouble Osteoporosis Arthritis/Gout Spina Bifida Parathyroid Disease Artificial Heart Valve Stromach/Intestinal Issues Psychiatric Disease Artificial Heart Valve Stroke Blood Disease Asthma Cancer Blood Transfusion Itregular Heartbeat Chemotherapy Breathing Problems Icukemia Cold Sores/Fever Blisters Glaucoma Utiver Disease Consulsions Heart Attack/Failure Thybroid Disease Vellow Jaundice Heart Murmur Tonsilitis Contisone Medicine Heart Attack/Failure Tuberculosis Diabetes Heart Trouble/Disease Tumors or Growths Drug Addiction Hepatitis A Venereal Disease Emphysema Hepatitis B or C Radiation Treatments	Aspirin	Penicillin	Codeine		□Local Anesthetics	□Metal	Late
AIDS/HIV Rheumatism Frequent Headaches AIADS/HIV Scarlet Fever Low Blood Pressure Anaphylaxis Shingles Lung Disease Anemia Sickle Cell Disease Mitral Valve Prolapse Janemia Sinus Trouble Osteoporosis Artificial Heart Valve Stomach/Intestinal Issues Parathyroid Disease Artificial Heart Valve Stomach/Intestinal Issues Psychiatric Disease Artificial Heart Valve Stomach/Intestinal Issues Psychiatric Disease Artificial Heart Valve Concer Blood Disease Jattima Cancer Blood Transfusion Ilrregular Heartbeat Chemotherapy Breathing Problems Leukemia Cold Sores/Fever Blisters Glaucoma Liver Disease Convulsions Heart Attack/Failure Thyroid Disease Yellow Jaundice Heart Murmur Tonsilitis Cortisone Medicine Heart Trouble/Disease Tumors or Growths Drug Addiction Hemophilia Uverceal Disease Emphysema Heepatitis A Venereal Disease Emphysema Heepatitis A Dubers	□Sulfa Drugs	□Other					
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AnaphylaxisShinglesLung DiseaseAnemiaSickle Cell DiseaseMitral Valve ProlapseAnginaSinus TroubleOsteoporosisArtificial Heart ValveStomach/Intestinal IssuesParathyroid DiseaseArtificial Heart ValveStomach/Intestinal IssuesPsychiatric DiseaseArtificial Heart ValveStomach/Intestinal IssuesPsychiatric DiseaseArtificial Heart ValveCancerBlood DiseaseAsthmaCancerBlood TransfusionIrregular HeartbeatChemotherapyBreathing ProblemsIkidney ProblemsChest PainsGlaucomaIlver DiseaseCongenital Heart DisorderHay FeverSwelling of LimbsConvulsionsHeart Attack/FailureThyroid DiseaseQuellow JaundiceHeart MurmurTonsilitisCortisone MedicineHeart Trouble/DiseaseTuberculosisDiabetesHeart Trouble/DiseaseTuberculosisCorg AddictionHemophillaUllersEasily WindedHepatitis AVenereal DiseaseEmphysemaHepatitis B or CRadiation TreatmentsEpilepsy or SeizuresHeipsRecent Weight LossErcestive BleedingHigh Blood PressureRenal DiseaseFrequent CoughHigh Cholesterol	□AIDS/HIV			Rheumatism		□ Frequent Headaches	
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Renal Disease DFrequent Cough DHigh Cholesterol	□ Radiation Treat	ments	E	Epilepsy or Seizures		Herpes	
	□Recent Weight	Loss	Γ	Excessive Bleeding		☐ High Blood Pressure	
]Rheumatic Fever □Frequent Diarrhea □Hives/Rash	Renal Disease		E	Frequent Cough		☐ High Cholesterol	
	□ Rheumatic Feve	er	[Frequent Diarrhea		□Hives/Rash	

To the best of my knowledge, the questions on this form were answered to the best of my knowledge and by providing incorrect information it can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any future changes.

Signature of patient or guardian

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Patient Registration

Full Name:			Date:	
Last	First	MI		
Address:				
Street Address		Apartment/Unit #		
City		State	Zip Code	
Cell Phone:	Home Phone:	Work F	hone:	
Email Address:				
Social Security Number:	Date of Birth:		Age:	
Male Female Sex:	Occupation:			
Your Employer	Leng	th of Employment:		
Ye Are you a full time student?				
	Insurance Informa	ition		
Person who holds insurance accou	nt:	Da	te of Birth:	
Employer:	Insurance Compa	ny:		
Social Security No. or ID Number c	n Insurance Policy		roup ID:	
Insurance Company Address:				
Insurance Company Phone Numbe	er:			
	Emergency Contact I	Person		
Full Name:		Relat	onship:	
Address:		Phone	e:	



INTERNET COMMUNICATION

Full Name:					Date:	
		Last	First	МІ		
□ Yes	🗆 No	l grant permission to the der myself and my children.	ments for			
		Email Address:				
□ Yes	🗆 No	I grant permission to the dental practice to contact me via text for upcom myself and my children.			ents for	
		Phone Number:				

HIPPA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you, Endres Gateway Dentistry, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payer (insurance company)
- The day-to-day healthcare operations of Endres Gateway Dentistry

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain a current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I give the following people permission to have access to my records:

Name:	Relationship to patient:	Phone Number:	
Name:	Relationship to patient:	Phone Number:	
Signature of Patient or Guardian:		Date:	
Print Patient's Name:			
Relationship to Patient:			