ENDRES GATEWAY DENTISTRY
"Oral Health is the Gateway to Healthy Living"

Dental History

Please check any of the following problems that apply to you.

☐Sensitivity (hot, cold, biting, sweets)
Where? ☐UR ☐UL ☐LR ☐LL
☐Headaches, earaches, neck pain
☐Jaw joint pain
☐Teeth or fillings breaking
☐Grinding or clenching teeth
☐Bleeding, swollen, or irritated gums
☐Loose, tipped, or shifting teeth
☐Bad breath/taste in mouth
☐Drinks soft drinks
☐Drinks coffee/tea

Do you have or have you had any of the following?

☐Dentures
☐Partial Dentures
☐Braces/Invisalign
☐Periodontal (Gum) Treatments
☐Oral Surgery
☐Night Guard or Retainer
☐Sleep Apnea Appliance

Please share the following dates:

Last cleaning_____

Last oral cancer screening_____

Last complete set of x-rays_____

Name/Phone number/Address of previous dentist

_____

_____
City State

_____
Phone Number

Reason for leaving previous dentist

_____

If you could whiten your teeth for a cost anyone could afford, would you do it?

☐Yes ☐No

If I could change my smile, I would:

☐Make them whiter
☐Make them straighter
☐Close spaces
☐Replace black fillings with tooth colored
☐Repair chipped teeth
☐Replace missing teeth
☐Replace old crowns that don't match
☐Have a smile makeover

Are you interested in facial esthetics such as Botox or Fillers?

☐Yes ☐No

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
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your visit today?

_____

What is the most important thing to you about the future of your smile?

_____

ENDRES GATEWAY DENTISTRY

"Oral Health is the Gateway to Healthy Living"

Medical History

Are you under the care of a physician?	☐ **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 thinners such as Warfarin, Xaralto, or Coumadin?	☐ **YES**	☐ **NO**	**If Yes**_____
Do you take or have you taken Fosamax, Bonivia, Actonel, or any other medication containing bisphosphonates?	☐ **YES**	☐ **NO**	**If Yes**_____
Have you ever been exposed to Tuberculosis?	☐ **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 taking?

Women:

☐ **Pregnant** ☐ **Nursing** ☐ **Taking oral contraceptives**

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Local Anesthetics ☐Metal ☐Latex

☐Sulfa Drugs ☐Other_____

Have you had or do you currently have any of the following conditions? ONLY CHECK IF YES

☐AIDS/HIV
☐Alzheimer's disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsilitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Radiation Treatments
☐Recent Weight Loss
☐Renal Disease
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestinal Issues
☐Stroke
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Yellow Jaundice
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Osteoporosis
☐Parathyroid Disease
☐Psychiatric Disease
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pacemaker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐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

X_____ Date:_____

ENDRES GATEWAY DENTISTRY
"Oral Health is the Gateway to Healthy Living"

Patient Registration

Full Name: _____ Date: _____
Last *First* *MI*

Address:_____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address: _____

Social Security Number:_____ Date of Birth:_____ Age:_____

Sex: Male ☐ Female ☐ Occupation:_____

Your Employer_____ Length of Employment:_____

Are you a full time student? Yes ☐ No ☐

If Patient is a minor we need mother and father's date of birth:_____

Insurance Information

Person who holds insurance account:_____ Date of Birth:_____

Employer:_____ Insurance Company:_____

Social Security No. or ID Number on Insurance Policy_____ Group ID:_____

Insurance Company Address:_____

Insurance Company Phone Number:_____

Emergency Contact Person

Full Name:_____ Relationship:_____

Address:_____ Phone:_____

ENDRES GATEWAY DENTISTRY
"Oral Health is the Gateway to Healthy Living"

INTERNET COMMUNICATION

Full Name: _____ Date: _____
Last *First* *MI*

☐ Yes ☐ No I grant permission to the dental practice to contact me via e-mail for upcoming appointments for myself and my children.

Email Address:_____

☐ Yes ☐ No I grant permission to the dental practice to contact me via text for upcoming appointments for myself and my children.

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:_____