

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?

Medical History

- | | | | |
|---|------------------------------|-----------------------------|--------------|
| Are you under the care of a physician? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Have you ever been hospitalized or had a major surgery? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Have you ever had a serious head or neck injury? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Do you use tobacco, vape, or marijuana? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Have you ever had a joint replacement? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Are you currently or have taken blood thinners
such as Warfarin, Xaralto, or Coumadin? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Do you take or have you taken Fosamax, Bonivia, Actonel,
or any other medication containing bisphosphonates? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Have you ever been exposed to Tuberculosis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Are you on a special diet? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If Yes _____ |
| Do you used controlled substances? | <input type="checkbox"/> YES | <input type="checkbox"/> 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**

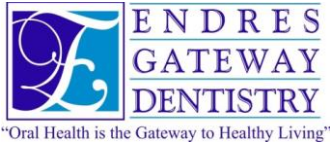
- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/>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



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: _____

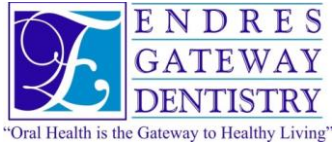
Insurance Company Address: _____

Insurance Company Phone Number: _____

Emergency Contact Person

Full Name: _____ Relationship: _____

Address: _____ Phone: _____



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: _____