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

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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____

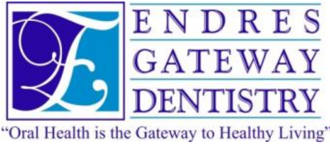
Have you had or do you currently have any of the following conditions? ONLY CHECK IF YES

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

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:________________

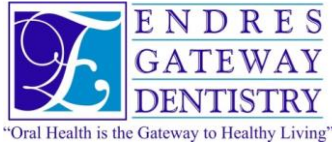
Insurance Company Address:____

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:____