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
☐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:_____

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

Financial Policy

Thank you for choosing Endres Gateway Dentistry, Inc. as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

When is my payment due?

If you do not have dental insurance, payment is due no later than at the time service is provided.

If you do have insurance, you must pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you; the balance is due within 30 days of the date service is provided. If your insurance company has not made payment within 25 days after the date of service was provided, we may ask that you contact your insurance company to make sure payment is expected by the 30th day following service. If payment is not received from your insurance company, or if your claim is denied, you will be responsible for paying the full amount by the 30th day following the day we provided service to you.

How can I make a payment?

We accept many forms of payment including credit card, cash, and check. Returned or dishonored checks will be subject to a "returned check" fee of $50.00 which will be immediately due and payable. Outside financing is available upon request and approval.

☐ **Please check if you would like more information about financing options**

How does Endres Gateway Dentistry deal with insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract.

- We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. Among other things, this form instructs your insurance company to make payment directly to us.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. We will not, however, enter into a dispute with your insurance company over any claim.

What happens if I do not comply with the terms of this financial policy?

If you fail to pay any amount when due, if any payment is returned, dishonored, or charged back by your financial institution, or you otherwise fail to comply with the terms of this financial policy, then you shall be liable for all expenses, including (without limitation) collection agency fees, attorneys' fees, and other litigation costs, relating in any way to the collection of any past due, dishonored, or charged back amount or your failure to comply with the terms of this financial policy.

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

What if I have questions or concerns about my bill?

If you have a question or concern about any bill you receive from us, please contact us immediately so that we can discuss the issue. We find that we can resolve most issues quickly and easily. Regardless, before filing any claim or lawsuit related to any dispute over any amounts charged by us in any court, you must firstly notify us of your claim in writing by emailing officemanager@endresdentistry.com. Your notice must reference this financial policy, fully explain the basis of your claim, and state your proposed resolution. Within 30 days of receipt of your notice, we will schedule a meeting between you and us, and at that meeting you must, in good faith, attempt to resolve the claim with us. If no meeting is scheduled within the stated time, or if the claim is not resolved at the meeting, then you may proceed with filing your claim or lawsuit. You hereby agree to the exclusive jurisdiction and venue of the state and federal courts in Hamilton County, OH for the resolution of any claim or dispute arising out of this financial policy or the services you receive from us.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of this financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO ENDRES GATEWAY DENTISTRY, INC.

Signature:_____ Date:_____
(Patient or Guardian)

Patient's Name:_____

ENDRES GATEWAY DENTISTRY

"Oral Health is the Gateway to Healthy Living"

Sleep Screening Questionnaire

Name _____ Date _____ DOB _____

Height _____Weight _____ BMI _____ Collar size/Neck circumference _____

	Yes	No
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly in a lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

Allergan MEDICAL INSTITUTE
Advancing Excellence in **Facial Aesthetics**

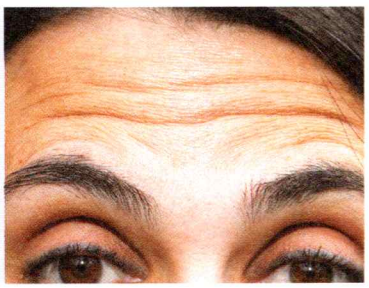
Patient Interest Questionnaire

Name: Age: Date: / /

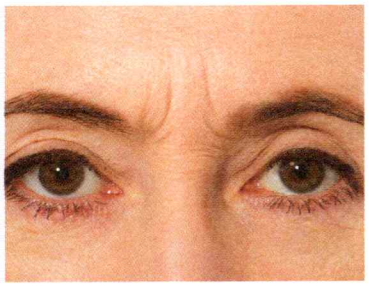
Please indicate any areas of concern for you

Check all that apply.

- ☐ Forehead lines

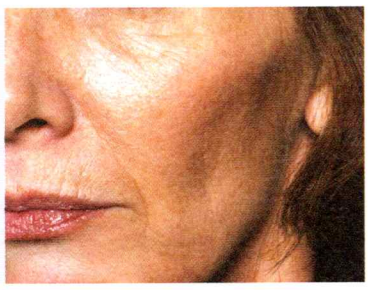


- ☐ Frown lines

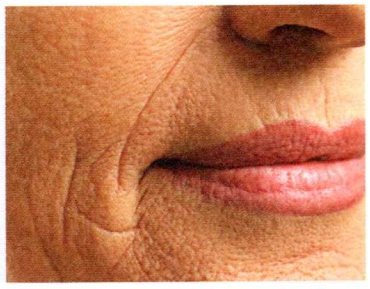


- ☐ Crow's feet lines

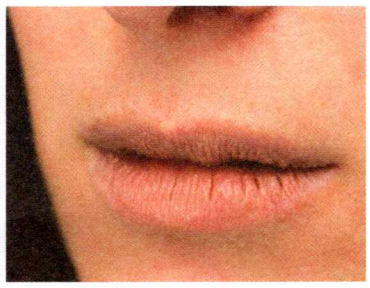
- ☐ Flattened cheeks/ sunken cheeks



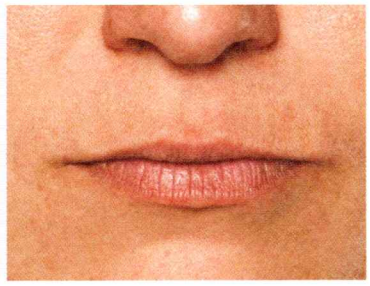
- ☐ Lines and wrinkles around the nose and mouth



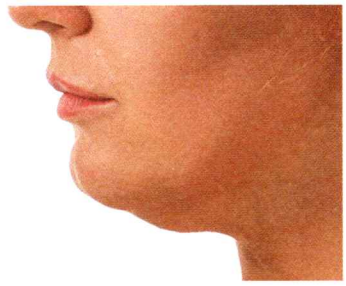
- ☐ Lip appearance and texture



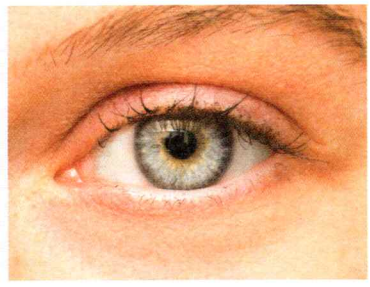
- ☐ Thin lips



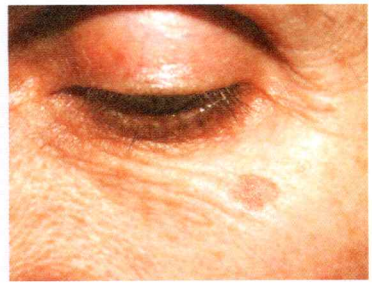
- ☐ Double chin



- ☐ Thinning or inadequate lashes



- ☐ Skin appearance and texture



Please complete questionnaire on back side.

Aesthetic specialist: See the next page to create the patient's treatment recommendations.

Allergan MEDICAL INSTITUTE
Advancing Excellence in **Facial Aesthetics**

Patient Interest Questionnaire

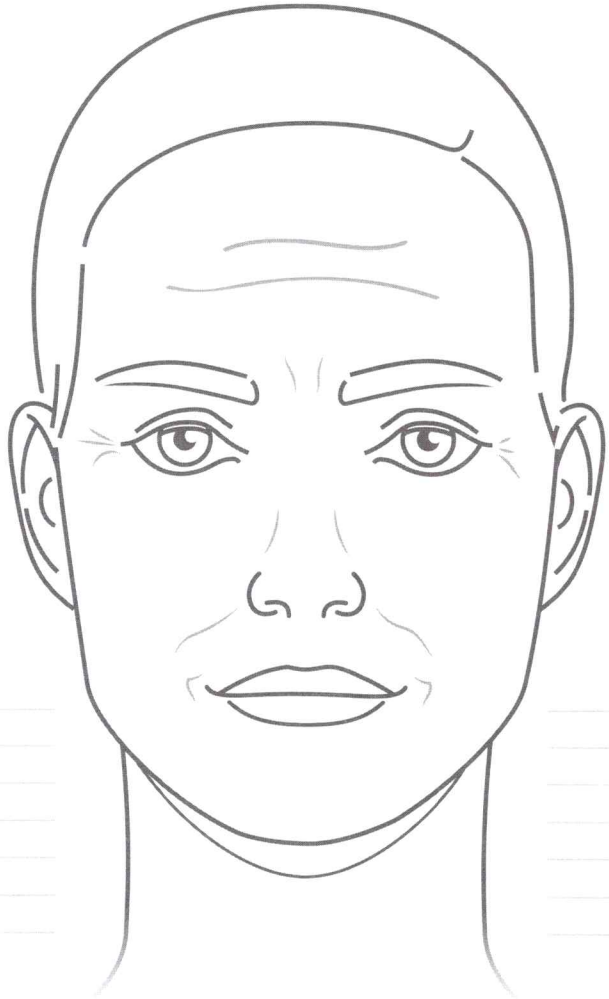
Share how you see yourself

I feel like I look:
Check all that apply.

- ☐ Sad
- ☐ Angry
- ☐ Tired
- ☐ Less lively
- ☐ Fearful
- ☐ Saggy
- ☐ Pained
- ☐ Less desirable
- ☐ Older than I feel
- ☐ Other _____

FOR USE WITH YOUR AESTHETIC PROVIDER

Evaluate concerns and aesthetic goals to customize each consultation



Patient name:

Next appointment date: / /