

# EQ Dental

3529 Heritage Trace Pwy #171  
Fort Worth/Keller, TX 76244  
T. 817.741.4567 | F. 817.741.4576

**Name:** \_\_\_\_\_  
FIRST NAME M.I. LAST NAME  
I prefer to be called \_\_\_\_\_  M  F  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address (if different): \_\_\_\_\_  
Home #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_  
Mobile #: (\_\_\_\_) \_\_\_\_\_ Other #: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_ How Long? \_\_\_\_\_  
May we call you at work?  Yes  No  
Best time to reach you and at which phone number?  
 AM  Afternoon  PM **AND**  Home  Work  Mobile  Other  
Email Address: \_\_\_\_\_  
Who may we THANK for referring you? \_\_\_\_\_  
FIRST NAME LAST NAME  
Do you have any family members that come  
if so, who? \_\_\_\_\_  
Name of Person Financially Responsible: \_\_\_\_\_  
FIRST NAME LAST NAME  
Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
If child, lives with:  Both Parents  Mom  Dad  Other

## PARENT/GUARDIAN INFORMATION:

Name: \_\_\_\_\_  M  F  
Home Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_

## SPOUSE OR ADD'L PARENT/GUARDIAN INFORMATION:

Name: \_\_\_\_\_  M  F  
Home Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_

## DENTAL INSURANCE Primary Dental Insurance

Ins. Co.: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_  
STREET ADDRESS  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
Ins. Phone 1: (\_\_\_\_) \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
FIRST NAME LAST NAME  
Group #: \_\_\_\_\_  
Policy Holder's Address if different from left: \_\_\_\_\_  
STREET ADDRESS  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_

## Secondary Dental Insurance

Ins. Co.: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_  
STREET ADDRESS  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
Ins. Phone 1: (\_\_\_\_) \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
FIRST NAME LAST NAME  
Group #: \_\_\_\_\_  
Policy Holder's Address if different from left: \_\_\_\_\_  
STREET ADDRESS  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_

## EMERGENCY CONTACT INFO:

In the event of an emergency, is there someone who lives near you that we should contact?  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Person Filling Out Form: \_\_\_\_\_  
Signed: \_\_\_\_\_  
Date: \_\_\_\_\_ Relation: \_\_\_\_\_

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Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 Answer all questions by checking Yes (Y) or No (N) Y N Previous Dentist \_\_\_\_\_ Last dental appointment \_\_\_\_\_

Are you in good health?  Y  N  
 Has there been any change in your general health in the past year?  Y  N  
 Do you have a personal physician?  Y  N  
 Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_  
 Are you now under a physician's care for a particular problem?  Y  N  
 Have you ever had any serious illnesses, operations or hospitalizations?  
 If so, describe: \_\_\_\_\_  Y  N  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Do your gums ever bleed?  Y  N  
 I brush \_\_\_\_\_ times a week and floss \_\_\_\_\_ times a week.  
 Are you currently in pain?  Y  N  
 Are you apprehensive about dental work?  
 No  Slight  Moderate  Extreme  
 Are you interested in sedation dentistry?  Y  N  
 How long has it been since you had your teeth cleaned?  
 3-5 months  6-9 months  10-12 months  \_\_\_\_\_ years  Never  
 Are you interested in learning more about:  
 Invisalign  Teeth Whitening  Implants  Orthodontics  
 How often do you visit the dentist?  Never  Checkups  Regularly

**DO YOU HAVE OR HAVE YOU EVER HAD:** Y N  
 = Click on each problem/matter within question.  
 Rheumatic Fever or Rheumatic Heart Disease?  Y  N  
 Congenital Heart Disease?  Y  N  
 Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur,  
 Coronary Artery Disease, Angina, High Blood Pressure, Stroke,  
 Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse?)  Y  N  
 Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis,  
 Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe  
 Coughing)?  Y  N  
 Seizures, Convulsions, Epilepsy, Fainting or Dizziness?  Y  N  
 Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do  
 you bruise easily?  Y  N  
 Liver Disease, Jaundice, Hepatitis A, Hepatitis B, Hepatitis C?  Y  N  
 Kidney Disease?  Y  N  
 Arthritis?  Y  N  
 Diabetes?  (  Diet Controlled  Meds Controlled )  Y  N  
 Thyroid Disease, Goiter?  Y  N  
 Stomach Ulcers, Collitis?  Y  N  
 Glaucoma?  Y  N  
 Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip,  
 Knee)?  Y  N  
 Chemo or Radiation treatment for Cancer?  Y  N  
 Clicking or popping of jaw joint, pain near ear, difficulty opening mouth,  
 grind or clench teeth?  Y  N  
 Sinus or Nasal problems?  Y  N  
 Any disease, drug or transplant operation that has depressed your immune  
 system (HIV/AIDS)?  Y  N

**ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:** Y N  
 Local Anesthesia (Novocain, etc.)?  Y  N  
 Penicillin or other antibiotics?  Y  N  
 Sedatives, Barbiturates?  Y  N  
 Aspirin or Ibuprofen?  Y  N  
 Codeine or other pain killers?  Y  N  
 Latex or Rubber Products?  Y  N  
 Other allergies or reactions? Please, list: \_\_\_\_\_

**ARE YOU USING ANY OF THE FOLLOWING:** Y N  
 Antibiotics?  Y  N  
 Anticoagulants (Blood Thinners)?  Y  N  
 Aspirin or drugs such as Motrin, Aleve, Ibuprofen?  Y  N  
 High Blood Pressure medications?  Y  N  
 Steroids (Cortisone, etc.)?  Y  N  
 Weight loss medications (Fen-Fen)?  Y  N  
 Tranquillizers and/or antidepressants?  Y  N  
 Insulin or Oral Anti-Diabetic drugs?  Y  N  
 Digitals, Inderal, Nitroglycerin or other heart drug?  Y  N  
 Are you taking or have you ever taken Bisphosphonates (such as  
 Fosamax or Actonel for osteoporosis, or chemotherapy for multiple  
 myeloma, etc.)?  Y  N  
 Recreational Drugs?  Y  N  
 Please list any and all medications taken, including prescription and over-  
 the-counter medications, herbal or holistic remedies, vitamins or  
 minerals: \_\_\_\_\_

Have you ever smoked or chewed tobacco?  Y  N  
 How much per day? \_\_\_\_\_ How long? \_\_\_\_\_  
 Do you have a history of Alcohol or Chemical Dependency or Emotional  
 Disorder?  Y  N  
 Have you had any serious problems associated with any previous dental  
 treatment?  Y  N  
 Have you or an immediate family member had any problem associated  
 with intravenous anesthesia?  Y  N  
 Do you have any other disease, condition or problem not listed above  
 that you think the doctor should know about?  Y  N  
 Do you wish to talk to the doctor privately about anything?  Y  N

**FOR WOMEN ONLY:** Y N  
 Are you Pregnant or is there any chance you might be Pregnant?  Y  N  
 Are you nursing?  Y  N  
 If you are using Oral Contraceptives, it is important that you understand that  
 antibiotics (and some other medications) may interfere with the effectiveness  
 of oral contraceptives. Therefore, you will need to use mechanical forms of  
 birth control for one complete cycle of birth control pills, after the course of  
 antibiotics or other medication is completed. Please consult with your  
 physician for further guidance.

I understand the importance of a truthful Health History to assist the  
 doctor in providing the best care possible. I have had the  
 opportunity to discuss my Health History with my doctor.  
 Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_

**OFFICE USE ONLY \* OFFICE USE ONLY**  
**MEDICAL UPDATE:** I have read my Health History dated \_\_\_\_\_  
 and confirm that it adequately states past and present conditions.  
 Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_  
 Changes: \_\_\_\_\_  
 Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_  
 Changes: \_\_\_\_\_

## Notice of Privacy Practices

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or assist with, aid in or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, other governmental or third party payers, or any organizations contracting with any of the above or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective immediately.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_