EQ Dental

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

Patient Name: _____ _____ _____ _____
First Last MI Preferred

Title: _____ **Gender:** ○ Male ○ Female **Marital Status:** ○ Married ○ Single ○ Child ○ Other
Mr./Ms./Mrs.

Birth Date: _____ **SS#:** _____-_____-_____ **Prev. Dental Visit:** _____

Phone: _____ _____ _____
Home Mobile Work

E-mail: _____ **Best Time to Contact:** _____

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

PRIMARY- Dental Insurance Information:

Insurance company: _____ **Insurance Telephone:** _____

Policy Holder: _____ **Policy Holder DOB:** _____ **Employer:** _____

Member Id: _____ **Group Number:** _____ **Relationship to Patient:** _____

SECONDARY- Dental Insurance Information:

Insurance company: _____ **Insurance Telephone:** _____

Policy Holder: _____ **Policy Holder DOB:** _____ **Employer:** _____

Member Id: _____ **Group Number:** _____ **Relationship to Patient:** _____

Emergency Contact Information:

Name: _____ **Relationship:** _____ **Phone:** _____

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Patient's Name: _____ **Patient's DOB:** _____ **Date:** _____

MEDICAL HISTORY: Please circle YES or NO

1. **Are you in good health?** **YES NO**
2. **Are you now under the care of a physician?** **YES NO**
3. **Have you ever been hospitalized or had a serious illness?** **YES NO**
   If YES, please explain: _____
4. **When was the last time you saw a physician?** _____

Are you allergic to OR have you had an adverse reaction to any of the following?

1. **Local anesthesia (Novocain etc.)** **YES NO**
2. **Penicillin or other antibiotics** **YES NO**
3. **Sedatives, barbiturates** **YES NO**
4. **Aspirin, Ibuprofen** **YES NO**
5. **Codeine or other pain killers?** **YES NO**
6. **Latex** **YES NO**

Other allergies or reactions: _____

Do you have OR have you ever had any of the following? Please circle YES or NO

- Heart Attack	YES	NO	- Kidney Disease	YES	NO
- Heart Murmur	YES	NO	- Congenital Heart Disease	YES	NO
- Rheumatic Fever	YES	NO	- Replacements- Hip/Knee/etc.	YES	NO
- Mitral Valve Prolapse	YES	NO	- HIV/ AIDS	YES	NO
- Pacemaker	YES	NO	- Nervousness	YES	NO
- High Blood Pressure	YES	NO	- Digestive Problems	YES	NO
- Low Blood Pressure	YES	NO	- Asthma	YES	NO
- Arthritis/ Rheumatism	YES	NO	- Hepatitis- A, B, C	YES	NO
- Thyroid	YES	NO	- Diabetes	YES	NO
- Cancer/ Tumors	YES	NO	- Anemia	YES	NO
- Epilepsy/ Seizures	YES	NO	- Liver Disease	YES	NO

Please list any other health conditions you may have or had: _____

_____

Are you currently taking any medications? _____

_____

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Patient's Name: _____ **Patient's DOB:** _____ **Date:** _____

DENTAL HISTORY: Please circle YES or NO

1. **What is the reason for your visit today?** _____
2. **When was the last time you saw your dentist?** _____
3. **Have you ever been treated for periodontal disease (gum disease)?** **YES NO**
4. **Have you had orthodontic treatment done (braces)?** **YES NO**
5. **Do you snore?** **YES NO**
6. **Have you ever had an unpleasant dental experience?** **YES NO**
   If yes, please explain: _____
7. **How often do you brush your teeth?** _____
8. **How often do you floss?** _____
9. **Do you smoke cigarettes or use smokeless tobacco?** **YES NO**
   If yes, how long and how much per day? _____
10. **Do you drink alcoholic beverages?** **YES NO**
    If yes, how much and how often? _____
11. **Do you experience any of the following? (Please circle all that apply to you)**

Bleeding or sore gums	**YES NO**	**Bad Breath**	**YES NO**
Dry Mouth	**YES NO**	**Swelling or Sore in mouth**	**YES NO**
Burning tongue/ lips	**YES NO**	**Popping/Clicking jaw**	**YES NO**
Grinding/ Clenching	**YES NO**	**Sensitive to sweets**	**YES NO**
Loose teeth	**YES NO**	**Food Trapping**	**YES NO**
Sensitive to Hot	**YES NO**	**Sensitive to Cold**	**YES NO**

WOMEN ONLY:

Are you pregnant or is there any chance you might be pregnant? **YES NO**
If yes, please provide your OBGYN info: _____

Are you nursing? **YES NO**