

Welcome to DR. Q DENTAL

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID# _____
Patient _____
Address _____
City _____
State _____ Zip _____
E-Mail _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Occupation _____
Patient Employer / School _____
Employer / School Address _____
Employer / School Phone () _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance?
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s) have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)
Dr. _____ all insurance benefits,

if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

PHONE NUMBERS

Home () _____ Work () _____ Ext _____ Cell Phone () _____
Spouse's Work () _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone () _____ Work Phone () _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath Yes No
Bleeding gums Yes No
Blisters on lips or mouth Yes No

Burning sensation on tongue Yes No
Chew on one side of mouth Yes No
Cigarette, pipe, or cigar smoking Yes No
Clicking or popping jaw Yes No
Dry mouth Yes No
Fingernail biting Yes No
Food collection between the teeth Yes No
Foreign objects Yes No
Grinding teeth Yes No
Gums swollen or tender Yes No
Jaw pain or tiredness Yes No
Lip or cheek biting Yes No
Loose teeth or broken fillings Yes No
Mouth breathing Yes No
Mouth pain, brushing Yes No
Orthodontic treatment Yes No
Pain around ear Yes No
Periodontal treatment Yes No
Sensitivity to cold Yes No
Sensitivity to heat Yes No
Sensitivity to sweets Yes No
Sensitivity when biting Yes No
Sores or growths in your mouth Yes No
How often do you floss? _____
How often do you Brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-Phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Place a mark on "yes" or "no" to indicate if you have any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, <small>with extractions or surgery</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/ growth (head or neck)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women:

Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

Aspirin Local Anesthetic

Barbiturates (Sleeping Pills) Penicillin

Codeine Sulfa

Iodine Other _____

Latex _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? Yes No If so, what? _____

Patient's Signature _____

Doctors Signature _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? Yes No If so, what? _____

Patient's Signature _____

Doctors Signature _____



CARIES RISK ASSESSMENT FORM (AGE >6)

Patient Name:		Birth Date:	
Age:	Date:	Initials:	

	Low Risk	Moderate Risk	High Risk
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Contributing Conditions		Check the conditions that apply		
I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at Mealtimes <input type="checkbox"/>		Frequent or prolonged between meal exposures/day <input type="checkbox"/>
III.	Caries Experience of Mother, Caregiver and/or other Siblings (for patients ages 6-14)	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>	Carious lesions in last 6 months <input type="checkbox"/>
IV.	Dental Home: Established patient of record, receiving regular dental care in a dental office.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

General Health Conditions		Check the conditions that apply		
I.	Special Healthcare Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral healthcare by themselves or caregivers)	No <input type="checkbox"/>	Yes (over age 14) <input type="checkbox"/>	Yes (ages 6-14) <input type="checkbox"/>
II.	Chemo/Radiation Therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
III.	Eating Disorders	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
IV.	Medications that Reduce Salivary Flow	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

Clinical Conditions (For Dr. Q's Use Only)		Check the conditions that apply		
I.	Cavitated or Non-Cavitated (incipient) Carious Lesions or Restorations (visually or radiographically evident)	No new carious lesions or restorations in last 36 months <input type="checkbox"/>	1 or 2 new carious lesions or restorations in last 36 months <input type="checkbox"/>	3 or more carious lesions or restorations in 36 months <input type="checkbox"/>
II.	Teeth Missing Due to Caries in past 36 months	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
III.	Visible Plaque	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
IV.	Unusual Tooth Morphology that compromised oral hygiene	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
V.	Interproximal Restorations- 1 or more	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
VI.	Exposed Root Surfaces present	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
VII.	Restorations with Overhangs and/or Open Margins; Open Contacts with food impaction	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
VIII.	Dental/Orthodontic Appliances (fixed or removable)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
IX.	Severe Dry Mouth (Xerostomia)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

Overall assessment of dental caries risk: Low Moderate High

Patient Instructions:



PREVENTATIVE, RESTORATIVE & COSMETIC DENTIST

DR.Q | CHARLYN QUIEC, DMD

139 E Colorado Blvd #1, Monrovia, CA 91016 | (626) 599,9818 | drq dental.net



TOTAL HEALTH CHECKLIST PATIENT: _____

This information will assist the dental professionals in assessing your oral health and its impact on your overall health. Please answer completely to the best of your knowledge.

Patient Name (Last Name, First Name): _____

Height: _____ Weight: _____

How frequently have you been brushing your teeth? _____

How frequently have you been flossing your teeth? _____

Do your gums bleed? Yes ___ No ___

Are your gums sore or swollen? Yes ___ No ___

Have your gums receded (do teeth look longer)? Yes ___ No ___

Are your teeth loose? Yes ___ No ___

Do you smoke or use tobacco products? Yes ___ No ___

Do you drink excessively? Yes ___ No ___

Do you have a persistent sore throat or ear pain? Yes ___ No ___

Do you have unexplained numbness or pain in the face/neck/mouth? Yes ___ No ___

Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more? Yes ___ No ___

Do you have chronic hoarseness? Yes ___ No ___

Do you have difficulty chewing, swallowing, or moving the jaw or tongue? Yes ___ No ___

Do you have a lump or thickening in the cheek? Yes ___ No ___

Do you snore or have you been told in the past you snore? Yes ___ No ___

Do you regularly have excessive daytime sleepiness? Yes ___ No ___

Have you been diagnosed with sleep apnea? Yes ___ No ___

Do you have a heart condition? Yes ___ No ___

Is there a history of heart disease in your immediate family? Yes ___ No ___

Do you have a family history of diabetes? Yes ___ No ___

Do you have high cholesterol? Yes ___ No ___

Do you have any other health conditions? Yes ___ No ___

FOR OFFICE USE ONLY

Record Blood Pressure:



PREVENTATIVE, RESTORATIVE & COSMETIC DENTIST

DR.Q | CHARLYN QUIEC, DMD

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SMILE EVALUATION

PATIENT: _____

Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take time to observe your teeth carefully. Then answer the following questions.

- 1** Do you like the appearance of your teeth, your smile? YES NO

If not, explain _____
- 2** Are your teeth all in alignment (straight)? YES NO

If not, explain _____
- 3** Do you have spaces that you don't like? YES NO

If yes, explain _____
- 4** Do you like the color of your teeth? YES NO

If not, explain _____
- 5** Do you like the shape of your teeth? YES NO

If not, explain _____
- 6** Are your teeth...? Chipped Protruding Hidden
- 7** Do you like how your teeth come together? YES NO

If not, explain _____
- 8** Are there old fillings or dental work that you don't like looking at? YES NO

If yes, explain _____
- 9** What would you like to change the most in the appearance of your teeth? _____

- 10** How would you like your teeth to look? _____
