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 tome for services rendered. I understand that I am financially responsible for all charges wheather 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 benifits or the benifits 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	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How oftern do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No	How often do you Brush? _____		
			Loose teeth or broken fillings	☐ Yes	☐ No			

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

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ 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 _____

PREVENTATIVE, RESTORATIVE & COSMETIC DENTIST
DR.Q | CHARLYN QUIEC, DMD
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ADA American Dental Association®

CARIES RISK ASSESSMENT FORM (AGE >6)

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

		Low Risk	Moderate Risk	High Risk
	Contributing Conditions	Check the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	Yes ☐	No ☐	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at Mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home:** Established patient of record, receiving regular dental care in a dental office.	Yes ☐	No ☐	
	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 ☐	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	Chemo/Radiation Therapy	No ☐	Yes ☐	Yes ☐
III.	Eating Disorders	No ☐	Yes ☐	
IV.	Medications that Reduce Salivary Flow	No ☐	Yes ☐	
	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 ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in 36 months ☐
II.	Teeth Missing Due to Caries in past 36 months	No ☐	Yes ☐	Yes ☐
III.	Visible Plaque	No ☐	Yes ☐	
IV.	**Unusual Tooth Morphology** that compromised oral hygiene	No ☐	Yes ☐	
V.	Interproximal Restorations- 1 or more	No ☐	Yes ☐	
VI.	**Exposed Root Surfaces** present	No ☐	Yes ☐	
VII.	**Restorations with Overhangs** and/or **Open Margins; Open Contacts** with food impaction	No ☐	Yes ☐	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	No ☐	Yes ☐	
IX.	Severe Dry Mouth (Xerostomia)	No ☐	Yes ☐	Yes ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

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Total Health™ BEYOND THE MOUTH

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:

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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? _____

_____

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APPOINTMENT CANCELLATION POLICY

Effective February 1, 2009, Dr. Q Dental will require notification of cancellation at least **48 hours** prior to the scheduled appointment. Failure to give notification will result in a **$50.00 cancellation fee.**

Dr. Q Dental will consider the appointment a "broken/canceled appointment" anytime a patient has not given the advanced notice required above or has failed to arrive within 10 minutes of the reserved time.

By signing below, I understand the above policy and will take responsibility for any $50.0 cancellation fee I may occur.

Patient Signature

Date