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 _____

DR. Q DENTAL
139. E. COLORADO BLVD. SUITE #1, MONROVIA, CA 91016 • TEL: 626.599.9818 • FAX: 626.599.9812

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 **$75.00 cancellation fee**.

Dr. Q Dental will consider the appointment a "broken/cancelled 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 $75.00 cancellation fee I may incur.

Patient Signature

Date

PREVENTATIVE, RESTORATIVE & COSMETIC DENTIST
DR.Q | CHARLYN QUIEC, DMD
139 E Colorado Blvd #1, Monrovia, CA 91016 | (626) 599.9818 | drqdental.net

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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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:

Informed Consent for Dental Prophylaxis. Exams. & X-rays

Dental Prophylaxis (Cleaning)

During dental Prophylaxis (Cleaning), I understand that it involves removing plaque and calculus above the gum line and will not include gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, or is severe then you should receive attention immediately and this office must be contacted.

Fluoride

For nearly 70 years, Studies have consistently shown that fluoride in water and applied to teeth is safe and effective in preventing dental decay in both children and adults. The use of fluoride reduces tooth decay by at least 25%. I understand that the use of Fluoride is recommended and encouraged. It is, however, my responsibility to let the dental staff know if I wish to not have fluoride applied.

Exam and X-rays

I understand that the initial visit as well as recall appointments may require radiographs in order to complete the examination, diagnosis and treatment plan.

At this office, we use digital imaging which uses less radiation than the typical X-ray. Since there is very little radiation, dental x-rays are extremely safe. There are two main types of dental x-rays: intraoral (meaning the X-ray film is inside the mouth) and extraoral (meaning the X-ray film is outside the mouth).

- **Intraoral X-rays** are the most common type of dental x-ray taken. These x-rays provide a lot of detail and allow your dentist to find cavities, check the status of developing teeth, monitor the general health of your teeth and jawbone. Some examples of these are Bitewing x-rays, periapical, and occlusal x-rays.
- **Extraoral X-rays** show teeth, but their main focus is the jaw and skull. These x-rays do not provide the detail found with intraoral x- rays and therefore are not used for detecting cavities or for identifying problems with individual teeth. Instead, extraoral x-rays are used to look for impacted teeth, monitor growth and development of the jaws in relation to the teeth, and to identify potential problems between teeth and jaws and the temporomandibular joint or other bones of the face. One example of that is the panoramic x-ray.

Patient Name:_____

Signature of Patient/Guardian:_____ Date:_____

Witness:_____ Date:_____