# Dr. Quinn Yu
Dentist

Dental Matrix Q

(909) 525-2525

13850 City Center Drive, Suite 5000
Chino Hills, CA 91709

www.DentalMatrixChinoHills.com
DentalMatrixChinoHills@gmail.com


## Patient Information Sheet

**Patient Name:**_____

**Chart #:**_____ **Date:** ____/____/_____

### Patient Information

Language: ☐ English ☐ Spanish Gender: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Name: _____
Address: _____
City: _____State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Home#:_____Work#:_____
Cell #: _____ Texting OK? ☐ Yes ☐ No
E-Mail Address: _____
Preferred method of communication
☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

### Responsible Party

Relationship to patient: ☐ Self ☐ Guardian/Parent ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____State: _____ Zip:_____
SSN #: _____ Date of Birth: _____
Home#:_____Work#:_____
Cell #: _____ Texting OK? ☐ Yes ☐ No
E-Mail Address: _____

### Employer Information

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed
Employer/School Name: _____
Occupation: _____
Address: _____
City: _____State: _____ Zip:_____
Phone #: _____ How Long? Year(s) Month(s)

### Emergency Contact

Relationship to Patient: ☐ Responsible Party ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____State: _____ Zip:_____
Home#:_____Work#:_____
Cell #: _____
Physician Name: _____ Phone #:_____

### Primary Insurance Information

Insurance Type: ☐ No Insurance ☐ HMO ☐ PPO/Indemnity ☐ Denti-Cal
Plan Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insurance ID #: _____ Policy #/Group #: _____
**Subscriber's Information (Primary Member)**
Relationship to Patient: ☐ Self ☐ Responsible Party ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Employer: _____

### Secondary Insurance Information

Insurance Type: ☐ No Insurance ☐ HMO ☐ PPO/Indemnity ☐ Denti-Cal
Plan Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insurance ID #: _____ Policy #/Group #: _____
**Subscriber's Information (Primary Member)**
Relationship to Patient: ☐ Self ☐ Responsible Party ☐ Spouse ☐ Other
Gender: ☐ Female ☐ Male
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
SSN #: _____ Date of Birth: _____
Employer: _____

**How did you hear about us?**
☐ 1-800-Dentist ☐ Flyer/Ad ☐ Insurance /Plan Referral: _____
☐ Sign/Building ☐ Marketing Representative: _____
☐ Yellow Pages ☐ Employer ☐ DDS Referral: _____
☐ Family/Friend ☐ Website ☐ Other: _____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. I authorize to receive information & alerts from Dental Matrix via text messages. I understand this program is completely voluntary and that text messaging rates & fees may apply as determined by my cellular provider. Dental Matrix is in no way responsible for any fees charged to me by my cellular provider. If at any time I wish to discontinue receiving text messages from Dental Matrix I must notify the office in writing to withdraw from the text program.

_____ _____
Signature of Responsible Party Date
(Parent or Legal Guardian if Patient is a minor)

Patient Information Update *Update is noting no major change in Patient Information

| Date | Signature | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# HEALTH HISTORY
## HISTORIA DE SALUD

CHART NO: _____

PATIENT NAME: _____ DATE (FECHA): _____

DATE OF BIRTH (FECHA DE NACIMIENTO): _____ SEX (SEXO): M F HEIGHT (ESTATURA): _____ WEIGHT (PESO LBS): _____

Answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be strictly confidential.

| | Yes | No |
|---|---|---|
| 1. Are you in good health? | ☐ | ☐ |
| 2. Has there been any significant change in your general health within the past year? | ☐ | ☐ |
| My last physical was on _____ | | |
| 3. Are you now under the care of a physician? | ☐ | ☐ |
| If so, what is the condition being treated _____ | | |
| The name and telephone # of my physician is _____ | | |
| Please list any medications you are taking: _____ | | |
| 4. Have you been hospitalized from a serious illness or operation within the last 5 years? | ☐ | ☐ |
| If so, explain _____ | | |
| 5. Do you have or have you had any of the following diseases or problems? | | |
| A. High or Low Blood Pressure? | ☐ | ☐ |
| B. Heart Conditions: Damaged/Artificial heart Valves, Cardiovascular disease, murmurs, coronary insufficiency/occlusion, stroke, heart lesions or Mitral Valve Prolapse? | ☐ | ☐ |
| • Do you have pain in chest upon exertion? | ☐ | ☐ |
| • Are you ever short of breath after mild exercise? | ☐ | ☐ |
| • Do your ankles swell? | ☐ | ☐ |
| • Do you get short of breath when you lie down or do you require extra pillows when you sleep? | ☐ | ☐ |
| • Do your ankles swell? | ☐ | ☐ |
| C. Do you have a cardiac pacemaker? | ☐ | ☐ |
| D. Do you have Rheumatic Fever/Heart Disease? | ☐ | ☐ |
| • Sinus trouble? | ☐ | ☐ |
| E. Asthma? | ☐ | ☐ |
| F. Hives or skin rash? | ☐ | ☐ |
| G. Fainting spells or seizures? | ☐ | ☐ |
| H. Diabetes? | ☐ | ☐ |
| • Do you have to urinate (pass water) more than 6 times a day? | ☐ | ☐ |
| • Are your thirsty much of the time? | ☐ | ☐ |
| I. Hepatitis, Jaundice or liver disease? | ☐ | ☐ |
| J. Arthritis? | ☐ | ☐ |
| K. Inflamatory rheumatism? (Swollen Joints) | ☐ | ☐ |
| L. Stomach ulcers? | ☐ | ☐ |
| M. Kidney trouble? | ☐ | ☐ |
| N. Tuberculosis? | ☐ | ☐ |
| O. Anemia? | ☐ | ☐ |
| P. A persistent cough or cough up blood? | ☐ | ☐ |
| • Do you have prosthetic hip or joint prosthesis, implants, bone plates or pins? | ☐ | ☐ |
| If so, what? _____ | | |
| 6. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? | ☐ | ☐ |
| • Do you bruise easily? | ☐ | ☐ |
| • Have you ever required a blood transfusion? | ☐ | ☐ |
| If so, explain _____ | | |
| 7. Have you ever taken Phen-fen? | ☐ | ☐ |
| 8. Do you drink Alcoholic Beverages? | ☐ | ☐ |

Conteste todas las preguntas y Llene los espacios en blanco cuando se impliqué, Las contestaciones a nuestras preguntas son únicamente para nuestros archivos, y se consideran confidenciales.

| | Si | No |
|---|---|---|
| 1. ¿Está usted en buena salud? | ☐ | ☐ |
| 2. ¿Ha habido cambio de su salud durante el último año pasado? | ☐ | ☐ |
| Mi último examen médico fue en _____ | | |
| 3. ¿Está ahora bajo atención médica? | ☐ | ☐ |
| Si es asi, que enfermedad se está tratando _____ | | |
| El nombre y # de teléfono demi médico es _____ | | |
| Por favor especifique cualquier medicamentos que está tomando: _____ | | |
| 4. ¿Ha estado hospitalizado de una enfermedad seria u operación dentro los últimos 5 años? | ☐ | ☐ |
| Si es asi, explique _____ | | |
| 5. ¿Tiene o ha tenido alguna de las siguientes enfermedades o problemas? | | |
| A. ¿Alla o Beja presión arterial? (sangre) | ☐ | ☐ |
| B. ¿Enfermedad del Corazón: Válvulas artificiales o, dalfades, insulficiencia cardiaca, oclusión coronaria, arteriosclerosis, sincope, Lesión cardiaca o Mitral Válvula Prolapsó? | ☐ | ☐ |
| • ¿Tiene dolor en el pecho cuando hace esfuerzo? | ☐ | ☐ |
| • ¿Le falta en el aire después de hacer algún ejercicio? | ☐ | ☐ |
| • ¿Se le hinchen los tobillos? | ☐ | ☐ |
| • ¿Cuándo se acuesta, le Falta aire para respirar o le faltan más almohadas para dormir? | ☐ | ☐ |
| C. ¿Tiene un marcapasos cardiaco? | ☐ | ☐ |
| D. ¿Fiebre/Infección reumática del corazón? | ☐ | ☐ |
| • ¿Problema de sinusitis? | ☐ | ☐ |
| E. ¿Asma? | ☐ | ☐ |
| F. ¿Ronches o sarpullido? | ☐ | ☐ |
| G. ¿Desmayos y sudores o ataques? | ☐ | ☐ |
| H. Diabetes? | ☐ | ☐ |
| • ¿Orina usted más de seis veces por día? | ☐ | ☐ |
| • ¿Tiene sed la mayoría del tiempo? | ☐ | ☐ |
| I. ¿Hepatitis ictericia o enfermedad del higado? | ☐ | ☐ |
| J. ¿Arthritis? | ☐ | ☐ |
| K. ¿Inflamación reumateca? (coyunturas inflamadas) | ☐ | ☐ |
| L. ¿Ulceras estomacales? | ☐ | ☐ |
| M. ¿Enfermedad del rifión? | ☐ | ☐ |
| N. ¿Tuberculosis? | ☐ | ☐ |
| O. ¿Anemia? | ☐ | ☐ |
| P. ¿Tos persistente o tos con sangre? | ☐ | ☐ |
| • ¿Tiene cadera o conjuntara prostética, implantes, placa de hueso ir tornilios? | ☐ | ☐ |
| Si es asi, que? _____ | | |
| 6. ¿Ha sangrado anormalmente, con una extracción dental, Cirugía o trauma? | ☐ | ☐ |
| • ¿Se moretea su piel fácilmente? | ☐ | ☐ |
| • ¿Ha requerido transfusión de sangre? | ☐ | ☐ |
| Si es asi, explique _____ | | |
| 7. ¿Ha tomado usted Phen-fen? | ☐ | ☐ |
| 8. ¿Usted toma bebidas alcoholicas? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 9. Do you smoke? | ☐ | ☐ |
| If so, how much _____ | | |
| 10. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? | ☐ | ☐ |
| 11. Are you taking any of the following: | | |
| A. Antibiotics or sulfa drugs? | ☐ | ☐ |
| B. Anticoagulants (Blood thinners)? | ☐ | ☐ |
| If so, what _____ | | |
| C. Medicine for high blood pressure? | ☐ | ☐ |
| D. Cortisone (Steroids)? | ☐ | ☐ |
| E. Tranquilizers? | ☐ | ☐ |
| F. Antihistamine? | ☐ | ☐ |
| G. Insulin, tolbutamide (ornase) or similar drug? | ☐ | ☐ |
| H. Digitalis or drugs for heart trouble? | ☐ | ☐ |
| I. Nitroglycerin? | ☐ | ☐ |
| J. Oral contraceptive or other hormonal therapy? | ☐ | ☐ |
| K. Biphosphanates or any other bone cancer medications? | ☐ | ☐ |
| 12. Are you allergic or have you reacted adversely to: | | |
| A. Local anesthetics? | ☐ | ☐ |
| B. Penicillin or other antibiotics? | ☐ | ☐ |
| C. Barbiturates, sedatives or sleeping pills? | ☐ | ☐ |
| D. Aspirin or Sulfa Drugs? | ☐ | ☐ |
| E. Iodine? | ☐ | ☐ |
| F. Codeine or other narcotics? | ☐ | ☐ |
| G. Latex or rubber products? | ☐ | ☐ |
| H. Other _____ | ☐ | ☐ |
| 13. Have you had any problems or serious trouble associated with any previous dental treatment? | ☐ | ☐ |
| If so, explain _____ | | |
| 14. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? | ☐ | ☐ |
| 15. Do you have, or have you had personal contact with anyone who has the following? (please select each) | | |
| ☐ A. Herpes ☐ B. Hepatitis | | |
| ☐ C. TB ☐ D. AIDS | | |
| ☐ E. Venereal Disease ☐ F. HIV | | |
| 16. Are you pregnant or think you might be? | ☐ | ☐ |
| 17. Are you nursing? | ☐ | ☐ |
| 18. Do you have any other medical, mental or physical problem/condition not listed above? (Autism, Down's Syndrome, etc.) | ☐ | ☐ |
| If so, explain _____ | | |

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN — DATE

_____ _____

SIGNATURE OF DOCTOR (Firma del Doctor) — DATE

| | Si | No |
|---|---|---|
| 9. ¿Usted Fuma? | ☐ | ☐ |
| Si es cierto, cuanto _____ | | |
| 10. ¿Ha tenido cirugía o rayos x para tratar algún tumor, creco, u otra enfermedad de la boca o labios? | ☐ | ☐ |
| 11. ¿Está tomando los siguientes medicamentos: | | |
| A. ¿Sulfamidas o antibióticos? | ☐ | ☐ |
| B. ¿Anticoagulantes (aclarar la sangre)? | ☐ | ☐ |
| Si es asi, que _____ | | |
| C. ¿Medicamento contra la alta presión? | ☐ | ☐ |
| D. ¿Cortisona (esteroide)? | ☐ | ☐ |
| E. ¿Tranquilizantes? | ☐ | ☐ |
| F. ¿Antihistaminico? | ☐ | ☐ |
| G. ¿Insulina, tobultamida o drogas similares? | ☐ | ☐ |
| H. ¿Para enfermedades del corazón? | ☐ | ☐ |
| I. ¿Nitroglicerina? | ☐ | ☐ |
| J. ¿Anticonceptivos orales u otra terapia hormonal? | ☐ | ☐ |
| K. ¿Biphosphanates o cuaesquiera otras medicaciones del cáncer de hueso? | ☐ | ☐ |
| 12. ¿Esta alérgico o ha reaccionado adversamente a: | | |
| A. ¿Anestesia local? | ☐ | ☐ |
| B. ¿Antibióticos o penicilina? | ☐ | ☐ |
| C. ¿Barbitúrico, sedantes o pastillas para dormir? | ☐ | ☐ |
| D. ¿Aspirina ir Drogas con solfas? | ☐ | ☐ |
| E. ¿Yodo? | ☐ | ☐ |
| F. ¿Codeina o otros narcóticos? | ☐ | ☐ |
| G. ¿Látex o productos de hule? | ☐ | ☐ |
| H. ¿Alguna otra _____ | ☐ | ☐ |
| 13. ¿Ha tenido algún problema después de haber tenido un tratamiento dental? | ☐ | ☐ |
| Si es asi, explique _____ | | |
| 14. ¿Está trabajando o está en una situación donde está expuesto regularmente a radiografías o alguna otra forma de radiación? | ☐ | ☐ |
| 15. ¿Usted tiene o ha estado en contacto personal con alguien con lo siguiente? (por favor de circular) | | |
| ☐ A. Herpes ☐ B. Hepatitis | | |
| ☐ C. Tuberculosis ☐ D. SIDA | | |
| ☐ E. Enfermedades Venéreas ☐ F. HVI | | |
| 16. ¿Está usted embarazada o piensa que si? | ☐ | ☐ |
| 17. ¿Está amamantando (dando pecho)? | ☐ | ☐ |
| 18. ¿Tiene usted alguna otra enfermedad o condición no mencionada anteriormente? (Autismo, Sindrome de Down, etc.) | ☐ | ☐ |
| Si es asi, explique _____ | | |

Yo he leido lo de arriba y he contestado este cuestionario de Salud totalmente. He dado a conocer todos los trastomos de que concocimiento. Además certifico que yo, el que firma, presto mi consentimiento para que hagan el uso de rayos X, reexaminación o cualquier tratamiento dental que sea de acuerdo o aconsejado.

_____ _____

FIRMA DEL PACIENTE — DATE

Medical Clearance required: ____Yes ____No

For: _____

Update to medical history/Actualizar* Historia de salud – *Update to noting no change in Medical History. Actualizar es notar ningun cambio en la Historia De Salud.

| DATE/FETCHA | COMMENTS/COMENTARIOS | PATIENT SIGNATURE/FIRMA DEL PACIENTE | DR. SIGNATURE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |