Dear Prospective Patient:

Welcome to IQ Dental Group!

The name says it all: IQ Dental Group is based first and foremost on the Values of Integrity and Quality. While one may think it should be obvious that all dental offices ought to follow these values, reality may unfortunately be less than ideal in some instances. In my experiences serving on a dental peer review committee and consulting for an insurance company managing grievance cases, I have seen time and again dentistry increasingly being devolved into a business process rather than a healthcare profession; dollars and cents sometimes dictated treatment decisions instead of doctor-patient rapport and clinical excellence. It disappoints me as a healthcare professional to see such trends.

Because of this, my staff and I are building up IQ Dental Group to be a different kind of dental practice. Our Mission is to be the dental provider of choice for our patients by delivering "Integrity in our Service and Quality in our Care." Please note that Integrity is our #1 Value and we seek to always do the right thing and maintain constant open and honest communications with our patients at all times. Because communications is a two-way process, we do also ask and expect that our patients openly communicate with us as well. We promise that we are always doing our very best to serve our patients and their oral healthcare needs. In return, we would appreciate that our patients be reasonable with and supportive of us as well.

Thank you for choosing IQ Dental Group to be your dental healthcare provider. I am supremely confident that you are going to be happy with your experiences with us and that this will be a long-term relationship built on mutual trust, respect, and understanding. At IQ Dental Group, we practice dentistry to our Values of Integrity and Quality, Affordability and Simplicity.

Welcome to a different kind of dental practice!

Sincerely,

-Andrew B Shi DDS MBA

Managing Dentist

Integrity Quality Affordability Simplicity

IQ Dental Group Confidential Patient Information Form

Today's Date: M_____D_____Y_____

Patient Name: Last_____First_____MI_____

Legally Responsible Party: Last_____First_____MI_____

Relationship to Patient:_____

Date of Birth: M_____D_____Y_____ **S.S.Number:**_____

Sex: M / F **Driver's License Number:**_____

Phone: Mobile_____Home_____Work_____

Email:_____

Mailing Address: Street_____Apt#_____

City_____State_____Zip_____

Marital Status: Married / Single / Divorced / Separated / Widowed

Occupation:_____**Employer / School:**_____

Person to contact in case of emergency:_____

Relationship to patient:_____**Phone:**_____

How did you hear about our office?_____

When and where was your last dental visit?_____

What procedures were done at that time?_____

How were your past dental experiences?_____

Please describe your oral hygiene habits:_____

What is/are your chief dental concern(s) today?_____

_____

_____

Any other information you would like us to know?_____

_____

_____

I certify that I have read and understood this form and that the above information is complete and accurate to the best of my knowledge:

*Patient or Legal Party Signature*_____*Date*_____

IQ Dental Group Dental Benefit Plan Information Form

Patient Name: Last_____First_____MI_____
Date of Birth: M_____D_____Y_____

Do you have Dental Insurance? Y / N
If YES, please complete this form. If NO, please disregard this form. At IQ Dental Group, we would be happy to see you and work with you with or without insurance.

Primary Dental Coverage Information Effective date:_____

Primary Dental Plan Name:_____Phone:_____

Group #:_____Policy/ID #:_____

Name of insured: Last_____First_____MI_____

Date of Birth: M_____D_____Y_____ Relationship to patient:_____

Address (if different from patient address):_____

_____

Secondary Dental Coverage Information Effective date:_____

Secondary Dental Plan Name:_____Phone:_____

Group #:_____Policy/ID #:_____

Name of insured: Last_____First_____MI_____

Date of Birth: M_____D_____Y_____ Relationship to patient:_____

Address (if different from patient address):_____

_____

IQ Dental Group Confidential Health History Form

Patient Name: Last_____First_____MI_____
Date of Birth: M_____D_____Y_____

1. **Are you in good general health?** Y / N

   If NO, please explain_____

2. **Are you allergic or sensitive to anything that you are aware of:**
   Latex: Y / N Penicillin: Y / N Sulfa: Y / N

   Tetracycline: Y / N Aspirin: Y / N Codeine: Y / N

   Metals: Y / N Anesthetics: Y / N Other: Y / N

   If YES, please explain_____

3. **Are you taking or have you taken any of the following in the past year:**
   Antibiotics: Y / N Pain Meds: Y / N Tobacco: Y / N

   BisPhosphonates: Y / N Weight Loss Meds: Y / N Blood Thinners: Y / N

   Over the Counter Medications: Y / N

   If YES, please explain_____

   Please list any and all prescription medications you are currently taking:

   _____

   _____

   _____

4. **Have you had any serious illnesses, significant change in health, hospitalizations, or operations within the last 3 years?** Y / N
   If YES, please explain_____

5. **Are you now under the care of a physician?** Y / N

   If YES, Explain_____

   Date and nature of last medical exam_____

   Name of primary physician:_____

   Contact information of physician:_____

   _____

6. **Women only: Are you or could you be pregnant?** Y / N How many months?____
   Are you nursing? Y / N Take birth control pills? Y / N

7. **All Patients: Do you have or have you ever had any of the following:**

High Blood Pressure: Y / N	Angina or Heart Attack: Y / N
Diabetes: Y / N	Stroke or Embolism: Y / N
Heart Problems/Murmur: Y / N	Rheumatism: Y / N
Joint Replacements: Y / N	Surgical stents/pins/plates/etc: Y / N
Pacemaker: Y / N	Artificial Heart Valve: Y / N
Transplants: Y / N	Surgeries/Operations: Y / N
Kidney Disease: Y / N	Dialysis: Y / N
Liver Disease or Jaundice: Y / N	Hepatitis: Y / N B / C
Blood Disease: Y / N	Hemophilia or Sickle Cell: Y / N
Respiratory Disease: Y / N	Asthma: Y / N
Fainting Spells: Y / N	Epilepsy or Seizures: Y / N
Gastrointestinal Disease: Y / N	Stomach Ulcers: Y / N
Venereal Disease: Y / N	Bone Disease: Y / N
Immunological Disease: Y / N	HIV+/AIDS: Y / N
Thyroid Disease: Y / N	Eye Disease or Glaucoma: Y / N
Tumors or Cancer: Y / N	Radiation/Chemotherapy: Y / N
Substance Abuse: Y / N	Psychiatric/Mental Condition: Y / N
Sinus Problems: Y / N	Dry Mouth: Y / N
Jaw/TMJ Problems: Y / N	Head and Neck Injuries: Y / N
Tobacco Use: Y / N	Eating Disorders: Y / N

Anything else about your health NOT mentioned above? Y / N

If YES to any of the above questions, please explain in detail:

_____

_____

_____

_____

8. **Have you taken prophylactic premedication antibiotics at prior dental visits?** Y / N
Have you had any problems at all with prior dental visits? Y / N

If YES please explain:_____

_____

I certify that I have read and understood this form and that the above information is complete and accurate to the best of my knowledge:

*Patient or Legal Party Signature*_____ *Date*_____

*Dentist's Signature*_____ *Date*_____

*Notes:*_____