Justin Courtney, DDS, PS
HT Tran, DDS, PS

CEDAR DENTAL GROUP

Welcome to our office, what can we help you with? _____
_____
_____

Are you in pain or have you been having pain? If so, please describe it: _____
_____
_____

How do you feel about the appearance of your teeth? _____
_____

Have you ever had a bad experience with a Dentist or Doctor? __ yes __ no

Patient Information

Name: _____ SS #: _____
Address:_____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell:_____ Work:_____
E-mail: _____
Sex: M ___ F ___ Birthday: _____ Married ___ Single ___ Widowed ___ Divorced ___
Employer: _____ Occupation: _____

How did you hear about our office? _____

In case of an emergency, we should contact: _____ Relationship: _____
Home phone: _____ Cell:_____ Work: _____

Dental Insurance (please show your card to the Front Desk)

Insurance Subscriber: _____ Relationship to patient: _____
Subscriber DOB (If different from patient):_____ Subscriber SS#: _____
Name of insurance company: _____
Group number: _____ ID number: _____

Dental History

Former Dentist: _____ City/State: _____
Date of last dental visit: _____ Date of last dental x-rays: _____
How often do you brush? _____ How often do you floss? _____
Check any that apply:

__ Bad breath
__ Bleeding gums
__ Blisters on lips/mouth
__ Burning sensation on tongue
__ Chew on one side of mouth
__ Cigarette, pipe or cigar smoking
__ Clicking or popping jaw
__ Dry mouth
__ Fingernail biting
__ Food collection between teeth
__ Foreign objects
__ Grinding teeth
__ Gums swollen/tender
__ Jaw pain or tiredness
__ Lip or cheek biting
__ Loose teeth/broken fillings
__ Mouth breathing
__ Mouth pain, brushing
__ Orthodontic treatment
__ Pain around ear
__ Periodontal treatment
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweets
__ Sensitivity when biting
__ Sores or growths in your mouth

Health History

Physician's name: _____ Date of last visit: _____

Check any that apply:

__ AIDS/HIV
__ Anemia
__ Arthritis, Rheumatism
__ Artificial heart valves
__ Artificial joints
__ Asthma
__ Back Problems
__ Bleeding abnormally, with extractions/surgery
__ Blood disease
__ Cancer
__ Chemical dependency
__ Chemotherapy
__ Circulatory Problems
__ Congenital heart lesions
__ Cortisone treatments
__ Cough, persistent or bloody
__ Diabetes
__ Emphysema
__ Epilepsy
__ Fainting or dizziness
__ Glaucoma
__ Headaches
__ Heart murmur
__ Heart problems
__ Hepatitis Type __
__ Herpes
__ High blood pressure
__ Jaundice
__ Jaw pain
__ Kidney disease
__ Liver disease
__ Low blood pressure
__ Mitral valve prolapse
__ Nervous problems
__ Pacemaker
__ Psychiatric care
__ Radiation treatment
__ Respiratory disease
__ Rheumatic fever
__ Scarlet fever
__ Shortness of breath
__ Sinus trouble
__ Skin rash
__ Smoking
__ Special diet
__ Stroke
__ Swollen feet or ankles
__ Swollen neck glands
__ Thyroid problems
__ Tonsillitis
__ Tuberculosis
__ Tumor or growth on head or neck
__ Ulcer
__ Venereal disease
__ Weight loss, unexplained

Do you wear contact lenses? _____

For Women

Are you pregnant? ____Due date:_____ Are you nursing? ____ Taking birth control pills?__

Medication

List any medications you are currently taking and why: _____

_____

Pharmacy name: _____ phone number: _____

Allergies

Check off any allergies that you have:

__ Aspirin
__ Barbiturates (sleeping pills)
__ Codeine
__ Iodine
__ Latex
__ Local Anesthetic
__ Penicillin
__ Sulfa
__ Other

Authorization

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____