Personalized Dental Care For The Entire Family

Peters Dental Associates

2508 Bay Area Blvd., Ste. 100
Houston, TX 77058
281-486-8061

Patient Information

Today's Date:_____

Name:_____
Last First Mi.

I prefer to be called:_____ ___ Male ___Female Birthday:___/____/____

Social Security #: _____ __Single __Married __Divorced __Widowed __Separated

Home Address:_____
Street
_____/_____/_____
City State Zip

Home Phone:(___)_____ Cell/Pager:(___)_____ Work Phone:(___)_____

Other Family Members Seen By Us:_____

Whom May We Thank For Referring You?_____

Employer:_____ Occupation:_____

Employer's Address:_____/_____/_____/_____
Street City State Zip

Email Address:_____

Spouse Information

Name:_____ Birthday:____/____/____ Social Security #:_____

Employer:_____ Work Phone:(___)_____ Cell Phone:(___)_____

Person Responsible For Account If Other Than Yourself

Name:_____
Last First Mi.

Relationship: _____ Social Security #:_____

Billing Address:_____/_____/_____/_____
Street City State Zip

Home Phone:(___)_____ Cell/Pager:(___)_____ Work Phone:(___)_____

Dental Insurance Information

Primary Insurance

Insurance Co. Name:_____ Phone:_____ Group #:_____

Insurance Co. Address:_____/_____/_____/_____
Street City State Zip

Insured's Name:_____ Insured's Social Security #:_____

Insured's Birthday:___/___/___ Relation:_____ Insured's Employer:_____

Secondary Insurance

Insurance Co. Name:_____ Phone:_____ Group #:_____

Insurance Co. Address:_____/_____/_____/_____
Street City State Zip

Insured's Name:_____ Insured's Social Security #:_____

Insured's Birthday:___/___/___ Relation:_____ Insured's Employer:_____

Peters Dental Associates
M.H. Peters, Jr., D.D.S.

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Patient Questionnaire & Acknowledgement of Review of Notice of Privacy Practices

Patient Name:_____ Date: _____

You may be contacted by Peters Dental Associates to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

		Please Circle One	
May we contact you at home?		Yes	No
May we contact you at work?		Yes	No
May we contact you via your cell phone?		Yes	No
May we leave a voice mail?	Home	Yes	No
	Work	Yes	No
	Cell	Yes	No

Can a message be left using our name and what the call is in reference to? Yes No

If there is anyone other than yourself that we can leave a message with if so please give his/her names and relation.

_____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. Please give their name and relation.

_____

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature Date

Dental History

Why Have You Come To The Dentist Today? _____

_____

Are You Currently In Pain __Yes __No

Are Your Teeth Sensitive __Yes __No If Yes, __Hot __Cold __Pressure __Chewing

Do Your Gums Ever Bleed? __Yes __No

Have You Ever Had Periodontal Disease? __Yes __No

Do You Have Mobility In Your Teeth? __Yes __No

Do You Require Antibiotics Before Dental Treatment? __Yes __No

Do You Prefer To Be Sedated For Dental Treatment? __Yes __No If Yes, __Nitrous Oxide __Valium __IV Sedation

Have You Had Any Head, Neck, Or Jaw Injuries? __Yes __No

Do You Clinch Or Grind Your Teeth __Yes __No

Is Your Bite Uncomfortable When Chewing or Biting? __Yes __No

Do You Experience Pain In Your Jaw Joints (TMJ)? __Yes __No If Yes, __AM __PM

Do Your Jaw Muscles Hurt? __Yes __No If Yes, __AM __PM

Do You Smoke? __Yes __ No If Yes, How much? _____

Previous Dentist: _____

Why Did You Leave Your Previous Dentist? _____

What Did You Like The Most About Your Previous Dentist?_____

What Did You Like The Least About Your Previous Dentist? _____

Smile Assessment

Are You Concerned With The Appearance of Your Teeth or of Your Smile? __Yes __No

Are You Concerned About The Whiteness or Lack of Whiteness of One Or More of Your Teeth? __Yes __No

Are You Concerned About The Position or Angle of One or More of Your Teeth? __Yes __No

Are You Concerned About The Shape of One or More of Your Teeth? __Yes __No

In Social Situations, Are You Sometimes Embarrassed By Your Teeth or Your Smile? __Yes __No

Do You Have Old Fillings or Existing Dental Treatment That Is No Longer Satisfactory To You? __Yes __No

Are You Interested In Learning More About Esthetic or Cosmetic Dentistry? __Yes __No

Please List Any Other Problems, Concerns, or Questions: _____

_____

Medical History

For Office Use

B.P. _____

Heart Rate _____

Are You Allergic To Any Of The Following?

Aspirin	__Yes __No	Latex	__Yes __No
Codeine	__Yes __No	Penicillin	__Yes __No
Dental Anesthetics	__Yes __No	Sedatives	__Yes __No
Erythromycin	__Yes __No	Sulfa Drugs	__Yes __No
Jewelry/Metals	__Yes __No	Tetracycline	__Yes __No

Please List Any Additional Drugs/Materials That Cause Allergic Reactions: _____

Are You Taking Any Of The Following?

Acetaminophen	__Yes __No	Blood Pressure Medication	__Yes __No	Nitroglycerin	__Yes __No
Antibiotics	__Yes __No	Cold Remedies	__Yes __No	Recreational Drugs	__Yes __No
Antihistamines	__Yes __No	Digitalis/Heart Medication	__Yes __No	Steroid/ Cortisone	__Yes __No
Aspirin	__Yes __No	Insulin/Diabetes Drugs	__Yes __No	Thyroid Medicine	__Yes __No
Blood Thinners	__Yes __No	Tranquilizers	__Yes __No		

Please List Any Additional Prescription , Over–The–Counter Drugs, Herbal Remedies, Vitamins Or Mineral You Are Taking: _____

_____

Do You Have Or Have You Experienced The Following?

Abnormal Bleeding	__Yes __No	Hemophilia	__Yes __No
Alcohol Abuse	__Yes __No	Hepatitis	__Yes __No
Anemia	__Yes __No	Herpes	__Yes __No
Arthritis	__Yes __No	High Blood Pressure	__Yes __No
Artificial Bones/Joints	__Yes __No	HIV/AIDS	__Yes __No
Asthma	__Yes __No	Kidney Problems	__Yes __No
Blood Transfusion	__Yes __No	Liver Disease	__Yes __No
Cancer / Chemotherapy	__Yes __No	Mitral Valve Prolapse	__Yes __No
Cosmetic Surgery	__Yes __No	Pacemaker	__Yes __No
Colitis	__Yes __No	Psychiatric Problems	__Yes __No
Congenital Heart Defect	__Yes __No	Radiation Treatment	__Yes __No
Diabetes	__Yes __No	Rheumatic Fever	__Yes __No
Difficulty Breathing	__Yes __No	Seizures	__Yes __No
Drug Abuse	__Yes __No	Shingles	__Yes __No
Emphysema	__Yes __No	Sinus Problems	__Yes __No
Epilepsy	__Yes __No	Stroke	__Yes __No
Fainting Spells	__Yes __No	Thyroid Problems	__Yes __No
Fever Blisters	__Yes __No	Tuberculosis (TB)	__Yes __No
Glaucoma	__Yes __No	Ulcers	__Yes __No
Hay Fever	__Yes __No	Venereal Disease	__Yes __No
Headaches	__Yes __No		
Heart Attack	__Yes __No	Are You Pregnant? __ Yes __ No	
Heart Surgery	__Yes __No	If so, which trimester are you in? __1 __ 2 __3	

Assignment Of Benefits And Financial Responsibility: The Undersigned, in requesting examination and/or treatment, authorize the release of all information (including x–rays) relating to that examination or treatment , to health service plans and insurance companies. I hereby authorize payment of dental benefits, otherwise payable to me, directly to Peters Dental Associates. I understand that I am financially responsible for any charges not paid by insurance and for all charges if my insurance claim is denied or if I do not have any insurance benefits. I agree to pay for any services rendered at the time of service unless other arrangements are made by the treatment coordinator.

Patient Signature (Or Responsible Party): _____ Date: _____