

**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: _____



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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?	Yes	No
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

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

For Office Use

B.P. _____

Heart Rate _____

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: _____