Deer Park Family Dentistry
Karen Jane Reeves D.D.S.
Jason Peck D.D.S.
Troy Tregre D.D.S.

4518 Center St.
Deer Park, TX 77536
Telephone: (281)479-2841
Fax: (281)479-6238

Date:________________

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name | M.I. | Last Name | Preferred Name

Age | Social Security | Date of Birth

Home Address | City | State | Postal Code

Home Phone | Cell Phone | E-Mail

Occupation | Employer

☐ Check Here If Same As Above

Person Responsible For Account

First Name | M.I. | Last Name | Preferred Name

Age | Social Security | Date of Birth

Home Phone | Cell Phone | E-Mail

Dental Insurance Information

☐ Check here if you do not have dental insurance ☐ Check here if you previously provided information

Insurer's First & Last Name | D.O.B. | Social Security Number

Insurance Company | Subscriber ID # | Group #

Name of Insurer's Employer | Relationship to patient

Referral Information

How did you hear about our office? ☐ Friend/Relative ☐ Internet ☐ Drove by office

If you were referred to us, whom may we thank?______________________________

In Case Of An Emergency

In case of an emergency whom may we contact?______________________________

Relation to patient______________________Number______________________

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Dental Health History

(Print) ____
First Name MI Last Name D.O.B

Please check yes or no for those that apply to you

Yes	No		Yes	No	
☐	☐	Sensitivity to: **Hot or Cold**	☐	☐	Bleeding, swollen or irritated gums
☐	☐	Chipped/Broken teeth	☐	☐	Dissatisfied with appearance of your teeth
☐	☐	Crooked/Tipped/Rotated teeth	☐	☐	Frequent headaches
☐	☐	Loose teeth	☐	☐	Jaw joint pain
☐	☐	Missing or spaces between teeth	☐	☐	Grinding or clenching teeth
☐	☐	Catching food between teeth	☐	☐	Uncomfortable or uneven when I bite down
☐	☐	Dry mouth or constantly thirsty	☐	☐	Clicking or popping of the jaw
☐	☐	Smoke or use chewing tobacco	☐	☐	Difficulty opening or chewing

Please check yes or no if you have or have had:

Yes	No		Yes	No	
☐	☐	Dentures or partials	☐	☐	Veneers
☐	☐	Braces or clear braces	☐	☐	Jaw surgery
☐	☐	Periodontal disease or gum treatments	☐	☐	Root Canals
☐	☐	Fixed bridge	☐	☐	Mouth Guard/Occlusal Splint
☐	☐	Dental implants	☐	☐	C-Pap Machine or Oral sleep appliance
☐	☐	Crowns	☐	☐	Fear or Anxiety about dental treatment

If you could change your smile, I would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces or gaps that bother me
- ☐ Stop my jaw from hurting or clicking
- ☐ Replace dark metal filings with tooth colored
- ☐ Repair a chipped tooth
- ☐ Replace missing teeth
- ☐ Replace old crown/filing that look dark or discolored
- ☐ Have a smile makeover

On a scale 1-10, with 10 being the highest rating:

How important is your dental health to you? **1 2 3 4 5 6 7 8 9 10**
Where would you rate your current dental health? **1 2 3 4 5 6 7 8 9 10**

	Yes	No
Tell me about my options for replacing teeth with dental implants?	☐	☐
Have you ever whitened your teeth?	☐	☐

If this is your first time in our office please answer the following?

Date of last cleaning? ________/______ Date of last complete x-rays? ________/_______

What is the most important thing to you about your dental health? ______________________

Why did you leave your previous dentist? ______________________________________

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Health History

(Print)____
First Name MI Last Name D.O.B

Please check yes or no for those that apply to you

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV Positive	☐	☐	Heart conditions	☐	☐	Radiation (Head/Neck)
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Seizures/Epilepsy
☐	☐	Arthritis	☐	☐	Heart Surgery	☐	☐	Stomach problems
☐	☐	Artificial heart valve	☐	☐	Headaches	☐	☐	Stroke
☐	☐	Artificial joints	☐	☐	Hepatitis: A B C	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Herpes	☐	☐	Thyroid disease
☐	☐	Blood disease	☐	☐	High blood pressure	☐	☐	Ulcers
☐	☐	Bruise easily	☐	☐	Jaundice	☐	☐	Venereal disease
☐	☐	Cancer	☐	☐	Kidney disease	☐	☐	Respiratory problems
☐	☐	Chemotherapy	☐	☐	Liver disease	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Low blood pressure	☐	☐	Scarlet fever
☐	☐	Emphysema	☐	☐	Mitral valve prolapse			**Women Only:**
☐	☐	Excessive bleeding	☐	☐	Nervousness/Depression	☐	☐	Birth control
☐	☐	Fainting	☐	☐	Pacemaker	☐	☐	Nursing
☐	☐	Glaucoma	☐	☐	Periodontal disease	☐	☐	Pregnant

Do you have any of the following drug allergies or an adverse reaction?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Nitrous oxide
☐	☐	Codeine	☐	☐	Sulfa Drugs
☐	☐	Hydrocodone	☐	☐	Percodan
☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Latex	☐	☐	Antibiotics
☐	☐	Anesthetic			

Please list any other allergies you may have:________________________
____
____
____
____

Please check any of the following drugs you have used at any time?

Yes	No		Yes	No		Yes	No	
☐	☐	Fosamax	☐	☐	Boniva	☐	☐	Zometa
☐	☐	Actonel	☐	☐	Bisphosphonates	☐	☐	Skelid

List all medications you are currently taking. (Prescription and over the counter, Attach if needed)

____

____

____

I certify the information recorded on this medical and dental form is correct. I understand it is my responsibility to notify Deer Park Family Dentistry of any changes. I understand that I am financially responsible for all charges, whether or not paid by insurance. I understand if I withhold any information regarding allergies, medical conditions, medications or supplements; I agree not to have Deer Park Family Dentistry or any of its employees liable in the events of death or injury.

____
Signature (Parent/Guardian) Date

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Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____If so, what ______________________________

____

Date Signature (Parent/Guardian)

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____If so, what ______________________________

____

Date Signature (Parent/Guardian)

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____If so, what ______________________________

____

Date Signature (Parent/Guardian)

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____If so, what ______________________________

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Date Signature (Parent/Guardian)

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____If so, what ______________________________

____

Date Signature (Parent/Guardian)