

**Gentle Dentist**  
**Hermione A. White, D.D.S.**  
**13050 Louetta Rd.**  
**Cypress, Texas 77429**

**PATIENT REGISTRATION**

Id: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Patient is:  Policy holder Preferred Name: \_\_\_\_\_  
 Responsible Party Referred by: \_\_\_\_\_

**Responsible Party (If someone other than the patient)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Pager: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder

**Patient Information**

Address \_\_\_\_\_  
City \_\_\_\_\_ State/Zip \_\_\_\_\_ Pager \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Drivers Lic. \_\_\_\_\_  
E-mail: \_\_\_\_\_  I would like to receive correspondence via e-mail  
Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employment Status:  Full Time  Part Time  Retired Occupation: \_\_\_\_\_  
Student Status  Full Time  Part Time  
Preferred Pharmacy: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Remaining Benefits \_\_\_\_\_ Remaining Deductible: \_\_\_\_\_

**Patient Dental History**

**If pre-medication is necessary please call 281-376-0122.**

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nay sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	following extractions?		
Have you ever experienced any of the following			Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
problems in your jaw?			Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions		
Difficulty in opening or closing? .....	<input type="checkbox"/>	<input type="checkbox"/>	regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>

## Medical History

Patient Name: \_\_\_\_\_ Medical Dr. \_\_\_\_\_ Ph. # \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- |   | Yes                      | No                       |                       |
|---|--------------------------|--------------------------|-----------------------|
| Are you under a physician's care now? .....                     | <input type="checkbox"/> | <input type="checkbox"/> | If yes, explain _____ |
| Have you ever been hospitalized or had a major operation? ..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, explain _____ |
| Have you ever had a serious head or neck injury?.....           | <input type="checkbox"/> | <input type="checkbox"/> | If yes, explain _____ |
| Are you taking any medications, pills, or drugs? .....          | <input type="checkbox"/> | <input type="checkbox"/> | If yes, list _____    |
| Do you take, or have you taken, Phen-Fen or Redux?.....         | <input type="checkbox"/> | <input type="checkbox"/> | _____                 |
| Are you on a special diet?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____                 |
| Do you use tobacco? .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |                       |
| Do you use controlled substances? .....                         | <input type="checkbox"/> | <input type="checkbox"/> |                       |

**Women:** Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

**Are you allergic to any of the following?**

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  
Other If yes, please explain\_\_\_\_\_

**Do you have, or have you had, any of the following?**

- | Yes                      | No                       | Yes                      | No                       | Yes                      | No                       |
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Have you had any other illnesses not listed above? \_\_\_\_\_

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
 (Signature of patient (or parent if minor))

**Doctor's Comments** \_\_\_\_\_

\_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_