HAWKINS·RAINWATER
DENTAL GROUP

We are so delighted that you have chosen us as your dentist, and we are glad you are here. We look forward to taking care of you and your family. Thank you for taking time to provide your contact and insurance information along with completing the health questionnaire.

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Minor

Is anyone in your immediate family a current patient? ❑ Yes ❑ No Name:_____

Social Security #:_____ Birth Date:_____

Phone (Cell):_____ (Home):_____ (Work):_____

Email Address:_____

Address:_____

City:_____ State:_____ Zip:_____

Patient or Parent/Guardian's Employer:_____ Work Phone:_____

City:_____ State:_____ Zip:_____

Spouse or Parent/Guardian's Name:_____

Spouse or Parent/Guardian's Employer:_____

If student, name of school or college:_____

Emergency Contact Name:_____ Phone:_____

Whom may we thank for referring you?_____

Name of Insured:_____ Relationship:_____

Date of Birth:_____ Social Security #:_____ Date Employed:_____

Name of Employer:_____ Union/Local#:_____

City:_____ State:_____ Zip:_____

Insurance Company:_____ Group #:_____ Policy ID:_____

City:_____ State:_____ Zip:_____

Do you have additional insurance? If so, please complete the below:

Name of Insured:_____ Relationship:_____

Date of Birth:_____ Social Security #:_____ Date Employed:_____

Name of Employer:_____ Union/Local#:_____

City:_____ State:_____ Zip:_____

Insurance Company:_____ Group #:_____ Policy ID:_____

City:_____ State:_____ Zip:_____

Do you love your current smile? ❑ Yes ❑ No If not, what would you change?_____

_____

Have you ever had any of the following? Please check all that apply.

- ❑ AIDS/HIV
- ❑ Acid Reflux/GERD
- ❑ Anemia
- ❑ Angina/Chest Pains
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Autoimmune Disorder
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness/Vertigo
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Head Injuries
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Psychological Disorders
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis (active)
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease/STD
- ❑ Other:_____

Are you pregnant? ❑ Yes ❑ No

If so, due date:_____

Are you taking oral contraceptives?

❑ Yes ❑ No

Physician:_____ Phone:_____ Date of last exam:_____

1. Are you under medical treatment now? ❑ Yes ❑ No
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? ❑ Yes ❑ No

Explain:_____

3. Please list all medications: _____

_____

_____

_____

_____

_____

4. Have you ever taken any osteoporosis or cancer medications containing bisphosphonates (Fosamax, Boniva, Reclast, Actonel, etc)? If yes, please list the medication(s)_____ ❑ Yes ❑ No

_____

5. Do you use tobacco? ❑ Yes ❑ No
6. Do you use controlled substances? ❑ Yes ❑ No
7. Are you allergic to or have you had any reactions to the following?

Local anesthetics	❑ Yes ❑ No
Penicillin/Antibiotics	❑ Yes ❑ No
Sulfa Drugs	❑ Yes ❑ No
Barbiturates	❑ Yes ❑ No
Sedatives	❑ Yes ❑ No
Iodine	❑ Yes ❑ No
Aspirin	❑ Yes ❑ No
Metals	❑ Yes ❑ No
Latex	❑ Yes ❑ No
Other:_____	❑ Yes ❑ No

Previous dentist/location:_____ Date of last exam:_____

1. Do your gums bleed while brushing/flossing? ❑ Yes ❑ No
2. Are your teeth sensitive to hot/cold liquids, sweets or foods? ❑ Yes ❑ No
3. Do you feel pain with any of your teeth? ❑ Yes ❑ No
4. Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No
5. Have you had any head, neck or face injuries? ❑ Yes ❑ No
6. Have you experienced any of the following? Clicking/Pain in TMJ; Difficulty in opening/closing or chewing? ❑ Yes ❑ No
7. Do you have frequent headaches? ❑ Yes ❑ No
8. Do you clench/grind your teeth? ❑ Yes ❑ No
9. Have you had any orthodontic treatment? ❑ Yes ❑ No
10. Do you wear dentures/partials? ❑ Yes ❑ No

Date of placement:_____

11. Have you received oral hygiene instructions regarding the care of your teeth and gums? ❑ Yes ❑ No
12. Do you have or have you ever had Sleep Apnea? ❑ Yes ❑ No

I certify that I have read the above information and the questions have been accurately answered to my knowledge. I understand that providing incorrect information can be dangerous to my health. 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 initial bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependent's.

_____ _____

Patient's Signature or Parent/Guardian Signature Date