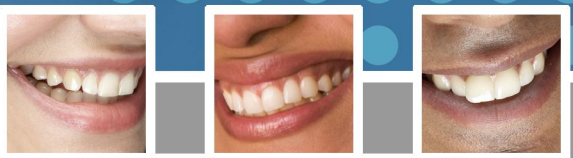
Hawkins Dental Group Inc.
5085 S. Soncy
Amarillo TX 79119

(806)353-4361



Patient Name: Last | First | MI | Preferred Name

Address:

City | State | Zip Code

Phone: Home | Work | Ext | Mobile

Best time to call:

Marital Status

○ Single ○ Married ○ Widowed ○ Other

Gender

○ Male ○ Female

Social Security Number | Date of Birth

Email Address

May we confirm your appointment by

○ email ○ text ○ both ○ neither

How did you hear about our office? Whom may we thank for referring you?

Emergency Contact and Phone Number

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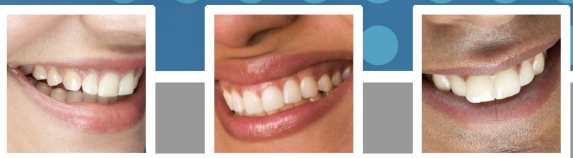

## Responsible Party

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Are you currently a patient in our office?

◯ Yes ◯ No

Has any member of your immediate family ever been a patient in our office?

◯ Yes ◯ No

If answered yes, please list name(s) and approximate date.

_____

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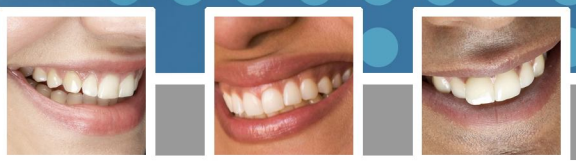

## Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

## Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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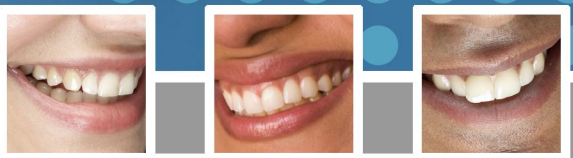

## Dental History

Reason for Today's Visit

Date of Last Exam? Last Dentist Seen? Date of Last Dental X-Rays?

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Clicking/Popping Jaw
- ☐ Loose or Broken Teeth/Fillings
- ☐ Grinding Teeth
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Bleeding Gums
- ☐ Collecting Food between Teeth
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Biting
- ☐ Sores in your Mouth

Have you ever worn Braces? When? Who was your orthordontist?

Have you had your wisdom teeth removed? When?

How often do you brush? What type of toothpaste and toothbrush do you use?

Is there anything about your smile that you would like to change? (ex. whiten, straighten)

Are there any questions or concerns that you would like us to address?

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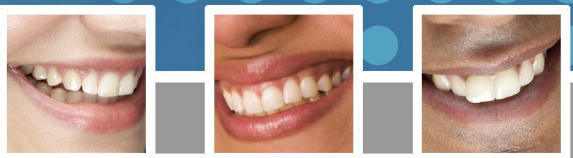

## Medical History

Physician's Name?  Date of Last Exam?  Phone Number?

Are in good Health?

Have you had any changes in your health in the last year? If yes, please explain.

Have you had any serious illness or injury?  If yes, please explain.

Have you ever taken or currently taking medication known as biophosphonates? (ex. Fosamax, Aredia, or Zometa)?  If yes give approximate dates.

Have you every taken any of the group of drugs known as "fen-fen" including Lonimin, Adipex, Fastin, Pondimin, and Redux?  If yes, give approximate dates.

Do you smoke or us smokeless tobacco? If yes, what type and how many years.

(Women) Are you pregnant or think you might be pregnant?

◯ Yes ◯ No

(Women) Are you Nursing?

◯ Yes ◯ No

(Women) Are you taking birth control pills?

◯ Yes ◯ No

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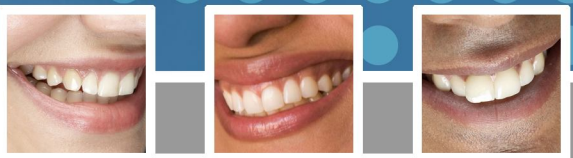

Check if you have or have had any of the following?

- [ ] Abnormal Heart Condition
- [ ] Acid Refulx
- [ ] Anemia
- [ ] Arthristis, Rheumatism
- [ ] Artifical Heart Valves
- [ ] Artifical Joints, Pins, Screws
- [ ] Asthma
- [ ] Back Problems
- [ ] Bleeding Problems
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependacy
- [ ] Chemotherapy
- [ ] Circulatory problems
- [ ] Congenital Heart Lesions
- [ ] Cortisone Treatments
- [ ] Cough, Persistent
- [ ] Cough up Blood
- [ ] Diabetes
- [ ] Epilepsy, Seizures
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches, Chronic
- [ ] Heart Murmur
- [ ] Heart Problems (Stints, etc.)
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/ AIDS
- [ ] Joint Replacement
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lung or Respiratory Disease
- [ ] Mitral Valve Prolaspe
- [ ] Pacemaker
- [ ] Radiation Therapy
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Shortness of Breath
- [ ] Stomach Problems, Ulcers
- [ ] Stroke
- [ ] Swelling of Feet or Ankles
- [ ] Thyroid Problems
- [ ] Tobacco Habbit
- [ ] Tuberculosis
- [ ] Veneral Disease

If yes to any of the above, please explain.

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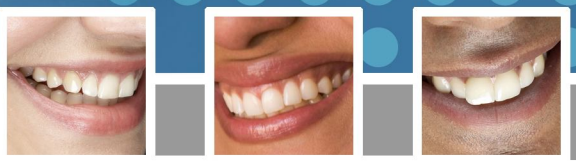

## Medications

List any medications , supplements, etc. that you are taking

Preferred Pharmacy and phone number.

## Allergies

Check any allergies that apply to you.

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine (other narcotics)
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other

If checked other please explain

Signature: _____ Date:

Response Date: