PATIENT INFORMATION

Date: _____

Patient Name: _____

SS#: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ (Home)

_____ (Work)

_____ (Cell)

Email: _____

Gender: Male ( ) Female ( ) Age: _____ Birthdate: _____

Marital Status: Married ( ) Widowed ( ) Single ( ) Separated ( )
Divorced ( ) Partnered for _____ Years Minor ( )

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

Employer Phone: _____

Spouse's Name: _____

Spouse's Birthdate: _____

SS#: _____

Spouse's Employer: _____

Spouse's Work Phone: _____

In case of emergency, who should we contact?

Name: _____

Relationship: _____

Phone Numbers: _____ (Home)

_____ (Work)

_____ (Cell)

Ronald E. Hawk, DDS, PA 951 NW 13th Street, Suite 3E Boca Raton, FL 33486
Phone: (561) 391-5242 Fax: (561) 394-8959 Web: www.hawkdentalartistry.com Email: info@hawkdentalartistry.com

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Is patient covered by additional insurance? ( ) Yes ( ) No

Subscriber's Name: _____

Birthdate: _____

SS#: _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ _____ (Insurance Company) and assign directly to Dr. Ronald Hawk all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Ronald Hawk may use my health care information any may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Dental History

Reason for today's visit: _____

Former dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	(_) Yes (_) No
Bleeding gums	(_) Yes (_) No
Blisters on lips or mouth	(_) Yes (_) No
Burning sensation on tongue	(_) Yes (_) No
Chew on one side of mouth	(_) Yes (_) No
Cigarette, pipe, or cigar smoking	(_) Yes (_) No
Dry Mouth	(_) Yes (_) No
Fingernail biting	(_) Yes (_) No
Food collection between the teeth	(_) Yes (_) No
Foreign objects	(_) Yes (_) No
Grinding teeth	(_) Yes (_) No
Gums swollen or tender	(_) Yes (_) No
Jaw Pain or tiredness	(_) Yes (_) No
Lip or cheek biting	(_) Yes (_) No
Loose teeth or broken teeth	(_) Yes (_) No
Mouth breathing	(_) Yes (_) No
Mouth pain, brushing	(_) Yes (_) No
Orthodontic treatment	(_) Yes (_) No
Pain around ear	(_) Yes (_) No
Periodontal treatment	(_) Yes (_) No
Sensitivity to cold	(_) Yes (_) No
Sensitivity to hot	(_) Yes (_) No
Sensitivity to sweets	(_) Yes (_) No
Sensitivity to biting	(_) Yes (_) No
Sores or growths in your mouth	(_) Yes (_) No

How often do you floss? _____

How often do you brush? _____

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Health History

Physician's Name _____

Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). (_) Yes (_) No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	(_) Yes (_) No
Anemia	(_) Yes (_) No
Arthritis, Rheumatism	(_) Yes (_) No
Artificial Heart Valves	(_) Yes (_) No
Artificial Joints	(_) Yes (_) No
Asthma	(_) Yes (_) No
Back Problems	(_) Yes (_) No
Bleeding abnormally with extractions or surgery	(_) Yes (_) No
Blood Disease	(_) Yes (_) No
Bruise easily	(_) Yes (_) No
Cancer	(_) Yes (_) No
Chemical Dependency	(_) Yes (_) No
Chemotherapy	(_) Yes (_) No
Circulatory Problems	(_) Yes (_) No
Congenital Heart Lesions	(_) Yes (_) No
Cortisone Treatments	(_) Yes (_) No
Cough, persistent or bloody	(_) Yes (_) No
Diabetes	(_) Yes (_) No
Emphysema	(_) Yes (_) No
Epilepsy	(_) Yes (_) No
Fainting or dizziness	(_) Yes (_) No
Glaucoma	(_) Yes (_) No
Headaches	(_) Yes (_) No
Heart Murmur	(_) Yes (_) No
Heart Problems	(_) Yes (_) No
Hepatitis Type _____	(_) Yes (_) No
Herpes	(_) Yes (_) No

High Blood Pressure	(_) Yes (_) No
Jaundice	(_) Yes (_) No
Jaw Pain	(_) Yes (_) No
Kidney Disease	(_) Yes (_) No
Liver Disease	(_) Yes (_) No
Low Blood Pressure	(_) Yes (_) No
Migraines	(_) Yes (_) No
Mitral Valve Prolapse	(_) Yes (_) No
Nervous Problems	(_) Yes (_) No
Pacemaker	(_) Yes (_) No
Psychiatric Care	(_) Yes (_) No
Radiation Treatment	(_) Yes (_) No
Respiratory Disease	(_) Yes (_) No
Rheumatic Fever	(_) Yes (_) No
Scarlet Fever	(_) Yes (_) No
Shortness of Breath	(_) Yes (_) No
Sinus Trouble	(_) Yes (_) No
Skin Rash	(_) Yes (_) No
Special Diet	(_) Yes (_) No
Stroke	(_) Yes (_) No
Swollen Neck Glands	(_) Yes (_) No
Thyroid Problems	(_) Yes (_) No
Tonsillitis	(_) Yes (_) No
Tuberculosis	(_) Yes (_) No
Tumor or growth on head or neck	(_) Yes (_) No
Ulcer	(_) Yes (_) No
Venereal Disease	(_) Yes (_) No
Weight Loss, unexplained	(_) Yes (_) No

Do you wear contact lenses? (_) Yes (_) No

Have you been told you need to PREMEDICATE or take antibiotics prior to a dental procedure?

(_) Yes (_) No

Which antibiotic do you take? _____

For what condition? _____

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Women

Are you pregnant? (_) Yes (_) No If yes, when is your due date? _____

Are you nursing? (_) Yes (_) No

Taking birth control? (_) Yes (_) No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

Allergies

(_) Aspirin (_) Iodine (_) Penicillin

(_) Barbiturates (sleeping pills) (_) Latex (_) Sulfa

(_) Codeine (_) Local Anesthetic

(_) Other _____

Updates

Has there been any change in your health since your last dental appointment? (_) Yes (_) No

If yes, please explain:

_____

_____

Are you taking any new medications? (_) Yes (_) No

If yes, please list:

_____

_____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Signature of Dentist Date

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