HOGAN FAMILY Dental

1820 Valley Drive East • (406) 234-2926
email: hfdental@midrivers.com
website: www.hoganfamilydental.com

Child's Name _____ Nickname _____ Sex (f) (m) DOB _____

Address _____ City _____ State _____ Zip _____

Name and age of brothers and sisters _____

Child's interests _____ Name of Pet _____

Child's attitude toward previous dental care _____ Any Phobias _____

Does your child have any special needs? _____

Child's learning: _____ slow _____ average _____ accelerated

Who may we thank for referring to us? _____

General Information:

Parent/Guardian Information _____ Mother _____ Stepmother _____ Guardian

Marital Status ____ Single _____ Married ____ Separated _____ Divorced _____ Widowed

Full Name _____ Preferred Name _____

DOB _____ SSN _____ Email _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Work # _____ Home # _____

Employer _____ Occupation _____

Parent/Guardian Information _____ Father _____ Stepfather _____ Guardian

Marital Status ____ Single _____ Married ____ Separated _____ Divorced _____ Widowed

Full Name _____ Preferred Name _____

DOB _____ SSN _____ Email _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Work # _____ Home # _____

Employer _____ Occupation _____

Emergency Contact Information (other than above)

Name _____ Relationship _____ Phone # _____

Insurance Information:

Please complete this section if you have dental coverage for this child.

Primary Insurance:

Policy Holder's Name _____ DOB _____ Employer _____

Secondary Insurance:

Policy Holder's Name _____ DOB _____ Employer _____

____ By initialing here, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity. I understand that I am financially responsible for any charges not covered by my insurance or this authorization for treatment of this child. Additionally, I authorized the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or to this child during the period of such dental care to third party payors and / or health care practitioners.

Dental History:

Purpose of visit _____ Concerns _____

Child's previous dentist _____ Date of last exam and x-rays _____

Would you like to remain with your child in the treatment area? _____ yes _____ no

How may we help to make this a positive experience for your child? _____

_____

Brushing, Flossing and Oral Habits

Do teeth get brushed every morning? ____ yes _____ no Evening? _____ yes _____ no

Who brushes the teeth? ____ child _____ adult _____ both

What kind of toothpaste? ____ none _____ with fluoride _____ without fluoride

How many times per week are teeth flossed? _____

Does your child currently have any oral habits? _____ yes _____ no (please check all that apply)

_____ thumb sucking _____ finger sucking _____ pacifier _____ Other

Nutrition and Snacking Habits

Is your child currently breastfeeding? ____ yes ____ no If so, during the night? ____ yes ____ no

Does your child use a bottle? ____ yes ____ no Does your child chew gum? ____ yes ____ no Sugarless?

Does your child use a sippy cup? ____ yes ____ no Beverages given in cup? _____

Does your child snack frequently? ____ yes ____ no Kinds of snacks? _____

Additional Dental History

Has your child had any injuries to the teeth, jaw, mouth or head? _____ If yes, please describe _____

_____

Is there any family history (including siblings) of dental issues, including cavities and missing teeth? ____ yes ____ no

Health History:

Is your child currently under the care of a physician? _____ If yes, please explain _____

_____

Child's Pediatrician _____ Phone Number _____

Has your child received all immunizations? _____

Is your child taking any medication or drugs? _____ If yes, please explain _____

Has your child ever been hospitalized? _____ Reason _____

Does your child have allergic reaction to:

_____ dyes _____ metals _____ food, please list _____

_____ latex _____ latex _____ medicines, please list _____

Has a child had a history or difficulty with any of the following: Please Check Yes or No

Yes	No		Yes	No		Yes	No	
___	___	ADD/ADHD	___	___	Delayed Development	___	___	Liver Disease
___	___	Abnormal Bleeding	___	___	Diabetes	___	___	Motion Sickness
___	___	Anemia	___	___	Earaches	___	___	Nosebleeds
___	___	Asthma	___	___	Emotional Issues	___	___	Premature Birth
___	___	Autism/Aspergers	___	___	Fainting or dizziness	___	___	Radiation Therapy
___	___	Reflux/GERD	___	___	Hearing Loss	___	___	Rheumatic Fever
___	___	Bleeding Disorder	___	___	Heart Condition	___	___	Seizures/Epilepsy
___	___	Bone Disorder	___	___	Hepatitis, HIV, AIDS	___	___	Speech Disorder
___	___	Cancer or Malignancies	___	___	Immune Disorder	___	___	Tonsillitis
___	___	Cystic Fibrosis	___	___	Kidney Disease	___	___	Tuberculosis

Additional Medical Information: _____

I certify that I have read and understand the above information to the best of my knowledge and questions have been accurately answered. I understand that providing incorrect information can be dangerous to this child's health. I give the dentist permission to use such measures deemed necessary in his / her professional judgment to render the best dental treatment for this child. I agree to be responsible for payment for all services rendered on my behalf or my dependents. I understand additional charges will be incurred as printed in the credit policy should I default on any payment.

Signature _____ Relationship _____ Date _____