HOGAN FAMILY Dental

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

Patient Information:

Name _____ Date of Birth ____/____/____

E-mail: _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient Employer _____ Full-time _____ Part-time _____

Purpose of Visit _____

How did you hear about us? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party:

Name of responsible party for this account _____ Employer _____

Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ SSN _____ DOB _____

For your convenience we offer the following methods of payment, please check your preference. Payment is expected in full at the time of service.

Cash_____ Personal Check_____ Credit Cards: *Visa*_____ Master Card_____ American Express_____ Discover_____ Care Credit_____

Previous Dental History:

Name of previous Dentist and location _____

Date of last exam _____

Do your gums bleed while brushing/flossing?_____

Are your teeth sensitive to sweet/sour and or hot/cold?_____Do you have pain with any of your teeth?_____

Do you have any sores or lumps in or around your mouth or jaw?_____

Have you had any head or neck injuries?_____

Have you experienced any of the following problems with your jaw?

_____Clicking _____Pain (joint, ear, side of face)

_____Difficulty with opening or closing _____Difficulty chewing

Do you have frequent headaches?_____Do you clench or grind your teeth? _____

Do you bite or chew your lips or cheeks frequently?_____

Have you had any difficult extractions in the past?_____Do you experience prolonged bleeding?_____

Have you ever received orthodontic treatment?_____

Do you wear dentures or partials?_____If yes, date of placement_____

Do you have dental implants?_____

Do you like your smile?_____Are you interested in teeth whitening?_____

Health History/Medications:

Medical Doctor: _____ Phone_____

Date of Last Visit_____ Reason _____

Have you ever taken Fen-Phen? ❑ Yes ❑ No Are you taking anti-coagulants (blood thinners)? ❑ Yes ❑ No

Have you ever taken Fosamax, Boniva, Actonel, or any other cancer medications containing bisphosphonates? ❑ Yes ❑ No

Begin Date_____End Date_____

Do you use tobacco? ❑ Yes ❑ No If yes: Chew_____Cigarettes_____How many?_____ How often? _____

Hospitalizations in the past 5 years?	Current Medications
	_____
	_____
	_____
	_____
	_____
	_____
	_____

Do you have allergies to any of the following medications or substances? *Please Check Yes or No*

Yes	No		Yes	No		Yes	No	
___	___	Aspirin	___	___	Barbituates	___	___	Iodine
___	___	Latex Rubber	___	___	Local Anesthetics	___	___	Metals
___	___	Penicillin or other Antibiotics	___	___	Sedatives	___	___	Sulfa Drugs
___	___	Other_____						

Medical Conditions: *Please Check Yes or No*

Yes	No		Yes	No		Yes	No	
___	___	AIDS/HIV	___	___	Heart Attack	___	___	Seizures
___	___	Anemia	___	___	Heart Disease	___	___	Sexually Transmitted Diseases
___	___	Angina	___	___	Heart Murmur	___	___	Stroke
___	___	Arthritis	___	___	Hepatitis	___	___	Swollen Ankles
___	___	Asthma	___	___	High Blood Pressure	___	___	Thyroid Problem
___	___	Cancer	___	___	Jaundice	___	___	Tuberculosis
___	___	Cardiac Pacemaker	___	___	Kidney Disease	___	___	Ulcers
___	___	Congestive Heart Failure	___	___	Leukemia	___	___	Joint Replacement - Date: _____
___	___	Diabetes	___	___	Liver Disease	___	___	Implant - Date: _____
___	___	Easily Winded	___	___	Low Blood Pressure			
___	___	Emphysema	___	___	Mitral Valve Prolapse			
___	___	Epilepsy/Convulsions	___	___	Osteoporosis			
___	___	Fainting	___	___	Radiation Therapy			
___	___	Frequently Tired	___	___	Recent Weight Loss			
___	___	Glaucoma	___	___	Rheumatic Fever			

WOMEN:
Are you pregnant? ❑ Yes ❑ No
#of weeks_____
Nursing? ❑ Yes ❑ No
Using oral contraceptives? ❑ Yes ❑ No

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 to my child during the period of such dental care to third party payors and/or health-care 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 I am financially responsible for all charges whether or not paid by my insurance. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

Signature of Patient_____**Date**_____