

RHONDA C. HOGAN, D.M.D., P.C.

1380 Peachtree Industrial Blvd. • Suite 150 • Suwanee, GA 30024 • 770-614-8914

Appt Date: ____/____/____

Patient Information

We welcome your child into our practice and we will try to make his/her dental experiences very pleasant.
Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Patient Name: _____ Nickname: _____
Last First MI

Male Female Siblings & Ages: _____

Social Security #: _____ Birth Date: _____ Age: _____

Phone (Home): _____ Grade: _____ Weight: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Has your child had or currently have any of the following? Please check those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Development Delays | <input type="checkbox"/> Medications: _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies/
Environmental
_____ | <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Excessive Bleeding | _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Food Allergy |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Behavioral Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizures | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Central line /Medi-Port | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Liver Disease | | |

• Has your child had any past surgeries? Yes No
If yes, please explain: _____

• Has your child been admitted to a hospital or needed emergency care during the past three years? Yes No
If yes, please explain: _____

• Name of Pediatrician: _____ Last Visit _____ Phone: _____

• Has your child had an unfavorable dental experience? Yes No
If yes, please explain: _____

• Does your child have a current or past history of: Thumb or finger sucking: _____ Pacifier _____

• Was your child breast fed: _____ Bottle fed _____ Age discontinued: _____

• What is your water source? Public System: _____ Private Well: _____ Bottled Water: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has a change in my health, I will inform the Dr. Hogan at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Parent Information

Father's Name: _____ Married Single
Last First MI

Social Security #: _____ Birth Date: _____ Email Address: _____

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

Address: _____
Street Apt.#

City State Zip Code
Employer Name: _____ Occupation: _____

Mother's Name: _____ Married Single
Last First MI

Social Security #: _____ Birth Date: _____ Email Address: _____

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

Address: _____
Street Apt.#

City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Information

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

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

Insurance Plan Name and Address: _____
Insurance Co. Phone #: _____

I hereby authorize payment of the dental benefits otherwise payable to me, directly to Dr. Hogan.

Signed (Employee/Subscriber): _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee **estimate** listed for this dental care can only be extended for a period of six months from the date of the patient examination.

The signature of the parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit denied.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____ Relationship to Patient: _____

PERMISSION FORM

I, _____, give permission to following parties listed below to keep on file:
(PARENT / GAURDIAN)

(RESPONSIBLE PARTY / RELATIONSHIP TO PATIENT)

(RESPONSIBLE PARTY / RELATIONSHIP TO PATIENT)

(RESPONSIBLE PARTY / RELATIONSHIP TO PATIENT)

to authorize dental treatment and/or change existing dental treatments for my child, _____.
(PATIENT)

This wavier allows the parties noted above to sign consent for treatment, decide for or against any treatment changes, and to be the responsible party if there should be an emergency. All necessary information regarding the patients visit will be given to the party noted above. If you, the parent/guardian, would like to speak with Dr. Rhonda Hogan or staff member, it will be your responsibility to call 770-614-8914 to receive this information. If there is a copay or patient portion due of the day of treatment, it is the parent/guardians responsibility to call in advance of the patient's appointment time to pay over the phone with a credit/debit card. No billing statements will be sent home for the amounts that are due day of service.

(PARENT / GAURDIAN SIGNATURE)

(DATE)