

GKAS
HOGAN FAMILY DENTAL
Health History and Permission Form

First _____ MI _____ Last _____

Date of Birth _____ Sex _____

Address _____
Street _____ City _____ Zip Code _____

Phone _____ Emergency _____

Does your child have or has your child had:

Asthma	Y	N	Congenital heart disease	Y	N
Heart Murmur	Y	N	Rheumatic heart disease	Y	N
Diabetes	Y	N	Bleeding problems	Y	N
Seizures	Y	N			

Is your child taking any medications? Y N

If yes, what medications? _____

Does your child have any allergies? Y N

If yes, what allergies? _____

Has your child had any other serious illness or operations? Y N

If yes, what illness or operation _____

Is there anything else we should know about the health of your child?

List _____

Who should we contact on the day of service to determine your child's care?

Name (print) _____ Phone _____

I give consent for my child to participate in the preventive and restorative dentistry program conducted by Hogan Family Dental. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I allow my child to receive local anesthetic (numbing of the teeth), fluoride, and radiographs as needed.

I give consent for my child's photograph to be taken for media coverage of this event and to further the mission of increasing access to dental care.

Name of Parent/ Guardian (Printed) _____

Signature _____ Date _____