Hauge Dental Clinic

Paul A. Hauge, D.D.S.

PATIENT INFORMATION

Date_____

First Name_____ MI____ Last_____ Male_____ Female_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Marital Status_____ DOB_____ Social Security #_____
Employer_____ Occupation_____
Work Address_____
Notify in Case of Emergency_____ Alt Phone_____
Driver License_____ (Not the same as your #)
Referred By_____

PRIMARY DENTAL INSURANCE

Person responsible for account_____ Relation to Patient_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ DOB_____ SS # or ID #_____
Employer_____ Occupation_____
Work Address_____ Work Phone_____
Insurance Company_____ Group #_____

SECONDARY DENTAL INSURANCE

Is this Patient covered by additional insurance? Yes No

Subscriber Name_____ Relation to Patient_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ DOB_____ SS # or ID #_____
Employer_____ Occupation_____
Work Address_____ Work Phone_____
Insurance Company_____ Group #_____

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DENTAL HISTORY

Former Dentist_____ Date of Last Visit_____
Check if you have had problems with any of the following:

☐ Bad Breath	☐ Bleeding Gums	☐ Grinding or Clenching
☐ Sensitivity to Sweets	☐ Sensitivity When Biting	☐ Periodontal Treatment
☐ Food Collection in Teeth	☐ Sores/Growths in Mouth	☐ Sensitivity to Cold
☐ Sensitivity to Hot	☐ Loose/Broken Teeth	☐ Clicking/Popping Jaw

How often do you Brush?_____ Floss?_____
Have you ever experienced an adverse reaction during or related to a medical or dental procedure?_____
Have you ever had Novocain?_____ Do you have an allergy to Novocain?_____

MEDICAL HISTORY

Physician's Name_____ Phone_____
Date of last visit_____ Have you had any serious illness or operation?_____
If yes, describe_____
Are you currently under physician care? Yes No If yes, describe_____
Have you ever had a blood transfusion? Yes No If yes, give approx. date_____
Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Circle if you have had any of the following:

AIDS/HIV Positive	Circulatory Problems	High Blood Pressure	Rheumatic/Scarlet Fever
Anaphylaxis	Diabetes	Jaw Pain	Shortness of Breath
Anemia	Epilepsy	Kidney Disease	Skin Rash
Arthritis	Fainting	Liver Disease	Stroke
Artificial Heart Valves	Food Allergies	Material Allergies	Surgical Implant
Asthma	Headaches	Mitral Valve Prolapse	Thyroid Disease
Blood Disease	Heart Problems	Nervous Problems	Tobacco Habit
Cancer	Hemophilia/Abnormal	Pacemaker/Heart	Tumors or Growths
Chemical Dependency	Bleeding	Radiation Treatment	Tuberculosis
Chemotherapy	Hepatitis	Respiratory Disease	Venereal Disease

Please explain any circled items:_____
List medications you are currently taking:_____
_____
List any drug allergies:_____

AUTHORIZATION

I have reviewed the information in this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all medical submissions.
I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.
Signature_____ Date_____