# *Hauge Dental Clinic*

Paul A. Hauge, D.D.S.

## CHILD INFORMATION

Date_____

First Name_____ MI____ Last_____ Male_____ Female_____
Address_____ City_____ State_____ Zip_____
Phone #_____ DOB_____ Social Security #_____
Notify in Case of Emergency_____ Phone_____
(Not the same as your #)

Mother's Name_____ DOB_____ Social Security #_____
Address (If different from Child)_____
Home Phone_____ Cell Phone_____ Work Phone_____
Employer_____ Occupation_____

Father's Name_____ DOB_____ Social Security #_____
Address (If different from Child)_____
Home Phone_____ Cell Phone_____ Work Phone_____
Employer_____ Occupation_____

Parents Marital Status Married Single Separated Divorced Widowed

Person Responsible for Child_____ Relationship_____

## 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 #_____

**Continued**

Your child's overall health, as well as any medications which your child takes, could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

## DENTAL HISTORY

Former Dentist_____ Date of Last Visit_____
How often does your child brush?_____ Floss?_____
Has your child had any difficulty with previous visits? Yes No
If yes, please explain:_____
Is your child's water fluoridated? Yes No
Does your child take a fluoride supplement? Yes No
Does your child suck their thumb/fingers? Yes No
Does your child suck/bite their lips? Yes No
Does your child bite/chew their nails? Yes No
Does your child chew on hard objects, such as pencils, etc? Yes No
Does your child grind their teeth? Yes No
Does your child clench their jaw? Yes No

## MEDICAL HISTORY

Physician's Name_____ Phone_____

Circle if your child has any of the following:

| | | | |
|---|---|---|---|
| Abnormal Bleeding | Congenital Heart Defect | Food Allergies | Material Allergies |
| AIDS/HIV | | Handicap/Disability | Rheumatic Fever |
| Asthma | Diabetes | Heart Murmur | Tuberculosis |
| Cancer/Hepatitis | Epilepsy/Convulsions | Hemophilia | |

Please explain any circled items or other medical conditions:_____
_____
List medications your child is currently taking:_____
_____
List any allergies:_____

### AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist all benefits, otherwise payable to me. I understand that I am financially responsible for all charges my child incurs whether or not paid by insurance.

Signature_____ Date_____
Relation to Child_____