

Nhu Q. Tran, DDS Pediatric Dentistry

Diplomate, American Board of Pediatric Dentistry

Tell Us About Your Child

				•	
Date		Social Security #	Birthdate		
Child's Name	Last Name	First Name	Middle Initial	F Child's Age	
Nickname			Pilotie Iritiai		
Home Address	Street	City	State		Zip
School Name			School Phon	e ()	
Person financia	Ily responsible	Home Phone ()	Work Phone	()	oostatimikased
What is the pri	mary reason for today's visi	t?	***************************************	Is your child adopted	? Yes No
			☐ Yes ☐ No If yes, name		
		Dona to L	famotia		
		rarents n	nformation		
Father's / Gua	rdian's Name		Mother's / Guardian's Name		
			Address (If different from patient		
Home Phone (Cell Phone ()w	ork Phone ()	Home Phone ()	Work Phone ()
Employer		***************************************	Employer		
Soc.Sec. #	Bi	rthdate	Soc.Sec. #	Birthdate	
Parents are:	☐ Married ☐ Separate	d Divorced Name of parent	who resides with the child:	*******************	
Nearest relativ	re: A	ddress		Phone ()	
Do you have d	lental insurance coverage fo	or minor/child? Yes No	Do you have dental insurance co	verage for minor/child?	☐ Yes ☐ No
Plan Name	Ph	none	Plan Name	Phone	
Address			Address		
Group #	Po	licy #	Group #	Policy #	
		Dental	History		
	Date of last visit to a der		For what service?		
	Has child complained abo		NO Is fluoride taken in any form	YES NO	
	Does child brush teeth da	aily?	☐ Any injuries to mouth, teeth	, head? 🗆 🗆	
	Does child use floss ever	y day?	Any unhappy dental experie	nces?	
Cia.	Any mouth habits - thum	b/finger sucking, nail biting, mouth	breathing, pacifier, sleeping with bot	tle, etc? 🗆 🗆	653

Medical History

Authorization and Consent for Treatment of a Minor/Child To the best of my knowledge, the information I have given on this form is complete and correct. I understand that providing incorrect information be dangerous to my child's health. I understand that it is my responsibility to inform the dental office of any changes in my child's health status/condition. I authorize Dr. Tran to release any information including the diagnosis and the records of any treatment or exam rendered to my child during period of such dental care to third party payors and/or other health practitioners. I am the parent/guardian of please Print Name of Your Child I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered signature of Parent or Guardian Date Office Privacy Policy I have read/received a copy of Dr. Tran's Notice of Privacy Practices. I consent to their use and disclosure of my child's Protected Health Information to carry out treatment, payment activities and healthcare operations.	Date of last physical examina						
Is Minor/Child under care of physician now? General Palsy				City/State		Phone()
Is Minor/Child under care of physician now? Medications Medications	Is Minor/Child under care of	ation		Results			
Is Minor/Child under care of physician now? Medications Medications	Is Minor/Child under care of		YES	NO			
Ever had surgery? Allergies Allergies Allergies		physician now?			ns		
If yes, please explain Ever had surgery?	Receiving any medication or	drugs?	🗆				
Ever had surgery? Allergies If yes, please explain	Ever been hospitalized?						
Is there excessive bleeding when cut?	If yes, please explain					*******	
Is there excessive bleeding when cut?	Ever had surgery?			☐ Allergies			
Has your child had any history of or difficulty with any of the following? If yes, please check () AIDS/HIV							
AIDS/HIV							
AIDS/HIV					sk ()		
ADD/ADHD	L.			The file of the file			
Anemia Cleft Lip/Palate Fainting Kidney Problems Seizures Asthma Congenital Birth Defects Hearing Problems Liver/GI Problems Sinus Problems Autism Congenital Heart Defects Heart Nurmur Lupus Sickle Cell Anemia Cancer/Tumors Diabetes Heart Problems Measles Tuberculosis Other Emergency Contact In the event of an emergency, whom should we contact? Name Relationship Phone () Name Relationship Phone () Authorization and Consent for Treatment of a Minor/Child To the best of my knowledge, the information I have given on this form is complete and correct. I understand that providing incorrect inform in be dangerous to my child's health. I understand that it is my responsibility to inform the dental office of any changes in my child's health attus/condition. I authorize Dr. Tran to release any information including the diagnosis and the records of any treatment or exam rendered to my child during eriod of such dental care to third party payors and/or other health practitioners. I am the parent/guardian or		The state of the s		The second second second second			. The second of
Asthma				A			
Autism	The second secon			1 3 Table 100 C	The state of the s		
Cancer/Tumors Diabetes Heart Problems Measles Tuberculosis	THE STREET STREET	Garage and the control of the contro		Date of the State		ıs	A STATE OF THE PARTY OF THE PAR
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