

Medical History

Minor/Child's Physician City/State Phone()

Date of last physical examination Results

Is Minor/Child under care of physician now? YES NO Medications
 YES NO

Receiving any medication or drugs?

Ever been hospitalized?

If yes, please explain

Ever had surgery? Allergies

If yes, please explain

Is there excessive bleeding when cut?

Has your child had any history of or difficulty with any of the following? If yes, please check ()

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Liver/GI Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> 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 information can 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 the period of such dental care to third party payors and/or other health practitioners.

I am the parent/guardian of and there are no court orders now in effect that prohibit me from signing this consent.
 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 to x-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.

.....
 Signature of Parent or Guardian Date

Financial Responsibility and Insurance Assignment/Release

I certify that my child is covered by dental insurance with(Name of Insurance Company(ies)) and assign directly to Dr. Tran all insurance benefits, if any otherwise payable to me for services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my child. I understand that it is my responsibility to inform the dental office of any updates, changes, and/or cancellation to my insurance carrier and/or policy. I authorize the use of my signature on all insurance submissions.

Dr. Tran may use my child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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 Signature of Parent or Guardian Date