WELCOME

Nhu Q. Tran, DDS, APC
Pediatric Dentistry
Diplomate, American Board of Pediatric Dentistry

Tell Us About Your Child

Date ..... Birthdate ..... Child's Age .....

Child's Name ..... Sex ☐ M ☐ F
Last Name First Name Middle Initial

Nickname ..... Hobbies .....

Home Address .....
Street City State Zip

School Name ..... School Phone ( ) .....

Person financially responsible ..... Home Phone ( ) ..... Work Phone ( ) .....

What is the primary reason for today's visit? ..... Is your child adopted? ☐ Yes ☐ No

Has any member of your family been or is currently a patient in our office? ☐ Yes ☐ No If yes, name .....

Whom may we thank for referring you? .....

Parent's Information

Father's / Guardian's Name .....

Address (If different from patient's) .....

.....

Home Phone ( ) ..... Work Phone ( ) .....

Cell Phone ( ) .....

E-mail .....

Employer .....

Soc.Sec. # ..... Birthdate .....

Mother's / Guardian's Name .....

Address (If different from patient's) .....

.....

Home Phone ( ) ..... Work Phone ( ) .....

Cell Phone ( ) .....

E-mail .....

Employer .....

Soc.Sec. # ..... Birthdate .....

Parents are: ☐ Married ☐ Separated ☐ Divorced Name of parent who resides with the child: .....

Nearest relative: ..... Address ..... Phone ( ) .....

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ..... Phone .....

Address .....

Group # ..... Policy # .....

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ..... Phone .....

Address .....

Group # ..... Policy # .....

Dental History

Date of last visit to a dentist ..... For what service? .....

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumb/finger sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ..... ☐ ☐

Please Complete Both Sides

Medical History

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

Date of last physical examination ..... Results .....

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications .....
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 ( )

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Drug/Alcohol Abuse	☐ Hemophilia	☐ Mononucleosis
☐ ADD/ADHD	☐ Chicken Pox	☐ Epilepsy	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cleft Lip/Palate	☐ Fainting	☐ Kidney Problems	☐ Seizures
☐ Asthma	☐ Congenital Birth Defects	☐ Hearing Problems	☐ Liver/GI Problems	☐ Sinus Problems
☐ Autism	☐ Congenital Heart Defects	☐ Heart Murmur	☐ 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 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.

....
Signature of Parent or Guardian Date