Medical History

Minor/ Child's Physician_____ City/State_____ Phone ( )_____

Date of last physical examination_____ Results_____

	YES	NO	
Is Minor/Child under care of physicians now?_____	☐	☐	Medications_____
Receiving any medication or drugs?_____	☐	☐	_____
Ever been hospitalized?_____	☐	☐	Allergies_____
If yes, please explain_____	☐	☐	_____
Is there excessive bleeding when cut?_____	☐	☐	_____

Has your child had any 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. Faeldan 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 your child's name

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/Guardian Date

Office Privacy Policy

I have read/received a copy of Dr. Faeldan'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/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. Faeldan 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. Faeldan 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/Guardian Date