



Please fax these documents to our Seattle Office at: 206.789.8961 or bring them to your first appointment.

## TREATMENT CONSENT FOR A MINOR

1. State Law requires us to obtain parental consent for dental treatment of a minor. Please read this form carefully and ask about anything that you do not understand.
2. In general terms the dental treatment may or may not include some of the following:
  - A. Radiograph (x-rays) of teeth and jaws
  - B. Cleaning and fluoride treatment
  - C. Sealants
  - D. Fillings
  - E. Extractions
  - F. Treatment of oral habits or growth abnormalities with orthodontics
  - G. Utilizing behavior management techniques when necessary (verbal consent from the parent must be given at that time)
3. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride, and children biting and injuring the tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze packing: injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of bacterial infection of the heart following dental treatment exist, therefore antibiotics will be prescribed before to minimize the risk.

**I hereby state that I have read and understand this consent form. I hereby authorize the doctors at Pacific Dental Care, assisted by other dental auxiliaries, to perform dental treatment on my child.**

Patient's Name \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Witness \_\_\_\_\_

DZON M. NGUYEN, DDS • SCOTT OKINO, DDS • THOA V. NGUYEN, DDS

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# PACIFIC DENTAL CARE

*Redefining Dental Care Through Innovation*

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Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Can we call you at work? Y N

Whom may we thank for referring you to our office? \_\_\_\_\_

## PRIMARY INSURANCE

Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

## SECONDARY INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber: \_\_\_\_\_

Subscriber's Date Of Birth: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to *Dr. Dzon M. Nguyen* all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-ray \_\_\_\_\_

Phone Number \_\_\_\_\_

**Please check the boxes that apply to you:**

- Head or neck injuries
- Bleeding gums
- Sensitive to hot cold sweets
- Gag easily

- Sores on lips/mouth that are slow to heal
- Chew on one side of mouth
- Anxiety of dental care
- Grind or clench teeth
- Clicking or popping jaw
- Dry mouth
- Difficulty chewing
- Food collection between the teeth
- Orthodontic treatment
- Stained teeth

- Loose teeth or broken fillings
- Gum swollen or tender

How often do you brush? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

Other comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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### HEALTH HISTORY

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Number \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Number \_\_\_\_\_

Place a mark on "Y" or "N" to indicate if you have and had any of the following:

AIDS/HIV+	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic fever or Scarlet fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Anemia or other blood disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Shortness of breath on mild exertion	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arteriosclerosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach or duodenal ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial joints or Heart Valves	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid or parathyroid disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis or Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chest pain on mild exertion	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tumor or abnormal growth	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Emotional problems or tension	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<b>Are You:</b>		
Excessively swollen ankles	<input type="checkbox"/> Y	<input type="checkbox"/> N	Presently being treated for any illness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Taking any medication regularly	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart trouble or Heart murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Aware of any recent weight change	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hepatitis or Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	Often thirsty or urinating	<input type="checkbox"/> Y	<input type="checkbox"/> N
High or Low blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Often exhausted and fatigued	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hives, skin rash, hay fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	Subject to frequent headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hospitalization for illness or surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N	A heavy smoker	<input type="checkbox"/> Y	<input type="checkbox"/> N
Kidney disease or Liver disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Often unhappy and depressed	<input type="checkbox"/> Y	<input type="checkbox"/> N
Mitral valve prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Prolonged bleeding due to a small cut	<input type="checkbox"/> Y	<input type="checkbox"/> N	<b>If Female, Are You Now:</b>		
Prostate disorders (if male)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Pregnant	<input type="checkbox"/> Y	<input type="checkbox"/> N
Psychiatric treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N	Taking birth control pills	<input type="checkbox"/> Y	<input type="checkbox"/> N
Radiation treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N	In menopause	<input type="checkbox"/> Y	<input type="checkbox"/> N
			Past menopause	<input type="checkbox"/> Y	<input type="checkbox"/> N

**Allergies:**

Aspirin       Codeine       Latex       Iodine       Ibuprofen       Sulfa       Erythromycin  
 Penicillin       Local Anesthetic       Acetaminophen       Sedatives (barbiturates)  
 Other \_\_\_\_\_

Medications:	Name & Dose	For	Name & Dose	For
	_____	_____	_____	_____
	_____	_____	_____	_____

**Notes**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Recall Date: \_\_\_\_\_

Recall Date: \_\_\_\_\_

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