



Please fax these documents to our Issaquah Office at: 425-391-5556 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 and direct Dr. Thoa Nguyen, assisted by other dentists and/or dental auxiliaries, to perform dental treatment on my child.

Patient's Name _____

Signature of Parent or Guardian _____ Date _____

Relationship to Patient _____ Witness _____



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 _____	<input type="checkbox"/> Sores on lips/mouth that are slow to heal <input type="checkbox"/> Chew on one side of mouth <input type="checkbox"/> Anxiety of dental care <input type="checkbox"/> Grind or clench teeth <input type="checkbox"/> Clicking or popping jaw <input type="checkbox"/> Dry mouth <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Food collection between the teeth <input type="checkbox"/> Orthodontic treatment <input type="checkbox"/> Stained teeth	<input type="checkbox"/> Loose teeth or broken fillings <input type="checkbox"/> Gum swollen or tender How often do you brush? _____ How often do you floss? _____ Other comments: _____ _____ _____ _____
Please check the boxes that apply to you: <input type="checkbox"/> Head or neck injuries <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Sensitive to <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> sweets <input type="checkbox"/> Gag easily		



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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 | Are You: | | |
| 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 | If Female, Are You Now: | | |
| 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: _____

Recall Date: _____

Recall Date: _____

Recall Date: _____

Recall Date: _____

Recall Date: _____

Recall Date: _____



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Payment, Financial, and Insurance Information

We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatment, and payment expectations.

We ask that all payments or co-payments be made at the time of service. For your convenience, we accept check, cash, Visa, MasterCard, and Care Credit.

Insurance: Our office is happy to help you process your insurance. We will complete our portion of the claim form and mail it promptly at no charge. To avoid confusion, it should be understood that insurance billing is an elective service provided to our patients. Difficulty obtaining insurance payment may occur, and **insurance payments CANNOT be guaranteed. Patient is solely and ultimately responsible for payment.**

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information _____ (please initial).

Scheduling Information

Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy.

Your appointment time is tailored for you. If the need arises to reschedule your appointment, please provide us at least **2 business days notice.**

Without adequate notification, we will not be able to give your reserved time to another patient in need of dental care. There is a **\$50.00 broken appointment fee** for every hour of the scheduled appointment. This fee covers the room preparation charge and the idle time of the Doctor, hygienist, and dental assistant who were on duty to provide your personalized care.

If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis.

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information _____ (please initial).

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager, Melissa Fuller.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of patient

Relationship (parent, etc.)

Patient Name

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

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