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 ______________________________

Thoa Nguyen, DDS   670 NW Gilman Blvd, Suite B3 Issaquah, WA 98027 (425) 55-SMILE   www.dentistryjustforkids.com

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

670 NW Gilman, #B3 - Issaquah, WA 98027 | 1421 NW 85th Street - Seattle, WA 98117

voice (425) 55-SMILE fax (425) 391-5556 | voice (206) 789-0111 fax (206) 789-8961