



PACIFIC DENTAL CARE

Redefining Dental Care Through Innovation

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

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	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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