



*Welcome* To our practice. Please take a few minutes to fill out this form as completely as you can. If you need help or have questions, we are glad to help you.

***Patient Information***

Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  
 Married  Separated  Divorced  Widowed

Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Physical Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work# \_\_\_\_\_

Driver's License \_\_\_\_\_ Soc. Sec# \_\_\_\_\_ Patient Employed by \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_ Notify in case of emergency & phone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone number \_\_\_\_\_

Are any of your family members patients in our office? \_\_\_\_\_ Relationship \_\_\_\_\_

***Dental Insurance***

Person Responsible for Account \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Address if different from patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone (if different from pt) \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

***Other Dental Insurance***

Person Responsible for Account \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Address if different from patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone (if different from pt) \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

I have reviewed the information above and it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# *El Portal Dental Group*

## **Financial Policy**

We at El Portal Dental Group are dedicated to serving you in caring for your oral health. We take great pride and care in providing the best in dental care to you and your family. Therefore, we will be more than happy to assist you with any financial matter related to your dental needs.

We ask for payment in full at each dental visit. To accommodate you with this we accept the following methods of payment:

- 1) Cash
- 2) Check
- 3) Credit Card (Master Card, Visa, Discover and American Express)
- 4) Care Credit, Citi Health, Chase, Spring Stone (with prior approval before your appointment)

For our patients with dental insurance, we will be happy to file your primary insurance claims for you at no charge. We will file a predetermination (per request) for any dental treatment that we deem necessary. The predetermination that we receive back from your insurance company is not a guarantee of payment. Your estimate portion is due in full at time that services are rendered.

Your insurance plan is an agreement between you and your Insurance Company. If your Insurance Company fails to make payment on your claim then the balance will become yours after sixty days. All accounts that go beyond sixty days past due will be transferred to Golden State Collection Agency. If payment is made on your claim and it is less than we originally estimated then the remaining balance, in full, will become your responsibility.

We firmly believe that the insurance company does not have the right to decide what course of treatment is best for you. Their decisions about your care are not always up to our standard of care and we refuse to neglect you, our patient, because of this.

By signing this form I authorize payment directly to Dr. Khang Nguyen (El Portal Dental Group) and I agree to abide by the following guidelines:

- A charge of \$25 will apply to my account if my check is returned for insufficient funds.
- I agree to keep all appointments as scheduled. If I am unable to keep my appointment I agree to give 48 hour notice. If I miss or break my appointment I understand I will be charged \$100.00.

I acknowledge that I have received and do understand Dr. Nguyen's financial policy.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient or Parent Signature if minor

\_\_\_\_\_  
Date

**El Portal Dental Group**  
**3385 G Street, Suite B**  
**Merced, CA 95340**

**Acknowledgement of Receipt of Notice of Privacy Practices**

Your name and signature on this sheet indicate that you have received a copy of El Portal Dental Group's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in El Portal Dental Group's Notice of Privacy Practices, please not hesitate to contact a staff member.

Patient Name (Printed) \_\_\_\_\_

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

If Patient Representative, Name (Printed): \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date Notice Received: \_\_\_\_\_

**The Dental Board of California Dental Materials Fact Sheet**

Adopted by the Board on October 17, 2001

The following document is the Dental Board of California's Dental Materials Fact Sheet. The department of consumer affairs has no position with respect to the language of this Dental Material Fact Sheet, and its linkage to the DCA website does not constitute an endorsement to the content of this document.

**I acknowledge I have received a copy of the Dental Material Fact Sheet**

Signature	Date	Revision Date

As required by Chapter 801, statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (based-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix title "Comparisons, of Restorative Dental Material." A glossary of Terms is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

# Informed Consent

**X-RAYS**

Benefits:

More complete diagnosis  
Can find hidden problems before they become big problems  
Can make a determination of treatment

Possible Complications:

Exposure to x-ray radiation (minimal)

Consequences of not having work done or Postponing:

Cannot perform dental services  
Increase risk of dental disease (pain & infection)

Alternatives:

None

**CLEANING & SCALING**

Benefits:

Looks nicer  
Clean Mouth  
Eliminate odors  
Prevent Gum Disease

Possible Complications:

Sensitive teeth  
Filling may be loosened (normal if filling was ready to fall out)  
Sensitive gums

Consequences of not having work done or postponing:

Stains on teeth  
Odors

Gum disease  
May lose teeth sooner

Alternative:

None

**LOCAL ANESTHETICS**

Benefits:

Avoid pain during treatments and procedures

Possible Complications:

Gum sores  
Prolonged numbness may extend beyond normal  
Nerve damage  
Bruising

In rare instances, possible consequences may include all those applicable to general Anesthesia, including allergic reactions up to and including death

Consequences of not having work done or postponing:

Mild to severe pain during and after treatment

Alternatives:

Willingness to accept pain during treatment

I give my consent to perform the treatment selected above. I have been informed and understand the Benefits, Complications, Consequences and Alternatives to procedures recommended.

\_\_\_\_\_  
Patient or Parent Signature if minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Witness for Dr. Nguyen

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**1. CIRCLE APPROPRIATE ANSWER:** (Leave blank if you do not understand the question)

- 1. Yes No Is your general health good? If no, explain \_\_\_\_\_
- 2. Yes No Has there been a change in your health within the last year? If yes, explain \_\_\_\_\_
- 3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If yes, explain \_\_\_\_\_
- 4. Yes No Are you being treated by a physician now? If yes, explain \_\_\_\_\_  
Date of last medical exam \_\_\_\_\_ Reason for exam \_\_\_\_\_
- 5. Yes No Have you had problems with prior dental treatment? If yes, explain \_\_\_\_\_
- 6. Yes No Are you in pain now? If yes, explain \_\_\_\_\_

**2. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING WITHIN THE LAST SIX MONTHS?** (Please Circle)

- |                                       |                                 |                            |
|---------------------------------------|---------------------------------|----------------------------|
| Yes No Chest pain                     | Yes No Blood in stools          | Yes No Frequent vomiting   |
| Yes No Fainting spells                | Yes No Diarrhea or Constipation | Yes No Jaundice            |
| Yes No Recent significant weight loss | Yes No Frequent urination       | Yes No Dry mouth           |
| Yes No Fever                          | Yes No Difficulty urinating     | Yes No Excessive thirst    |
| Yes No Night Sweats                   | Yes No Ringing in ears          | Yes No Swollen ankles      |
| Yes No Persistent Cough               | Yes No Headaches                | Yes No Joint pain          |
| Yes No Coughing up blood              | Yes No Dizziness                | Yes No Joint Stiffness     |
| Yes No Bleeding Problems              | Yes No Blurred Vision           | Yes No Shortness of Breath |
| Yes No Blood in urine                 | Yes No Bruise easily            | Yes No Sinus Problems      |
| Yes No Difficulty swallowing          |                                 |                            |

**3. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please Circle)

- |  |                                   |                           |
|--|-----------------------------------|---------------------------|
| Yes No Heart disease                   | Yes No AIDS/HIV                   | Yes No Psychiatric care   |
| Yes No Family history of heart disease | Yes No Surgeries                  | Yes No Osteoporosis       |
| Yes No Heart attack                    | Yes No Hospitalization            | Yes No Thyroid disease    |
| Yes No Artificial joint                | Yes No Diabetes                   | Yes No Asthma             |
| Yes No Stomach problems or ulcers      | Yes No Family history of diabetes | Yes No Hepatitis          |
| Yes No Heart defects                   | Yes No Tumors or cancer           | Yes No Heart murmurs      |
| Yes No Sexual transmitted disease      | Yes No Chemotherapy               | Yes No Herpes             |
| Yes No Rheumatic fever                 | Yes No Radiation                  | Yes No Canker/cold sores  |
| Yes No Skin disease                    | Yes No Arthritis, rheumatism      | Yes No Anemia             |
| Yes No Hardening of arteries           | Yes No Emphysema                  | Yes No Other lung disease |
| Yes No Liver disease                   | Yes No High blood pressure        | Yes No Eye disease        |
| Yes No Seizures                        | Yes No Kidney or bladder disease  | Yes No Transplants        |
| Yes No Stroke                          | Yes No Tuberculosis               | Yes No Cosmetic surgery   |
| Yes No Eating disorders                |                                   |                           |

**4. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?** (Please Circle)

- |   |                     |                     |
|---|---------------------|---------------------|
| Yes No Aspirin                                      | Yes No Valium       | Yes No Tetracycline |
| Yes No Darvon                                       | Yes No Demerol      | Yes No Vicodin      |
| Yes No Codeine                                      | Yes No Penicillin   | Yes No Percodan     |
| Yes No Local anesthetic<br>(Novacaine or Xylocaine) | Yes No Latex        | Yes No Food         |
| Yes No Nitrous oxide                                | Yes No Erythromycin | Yes No Metal        |
|   | Other: _____        |                     |

**5. HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**

- |                                   |                                 |                    |
|-----------------------------------|---------------------------------|--------------------|
| Yes No Recreational drugs         | Yes No Tobacco in any form      | Yes No Antibiotics |
| Yes No Over-the-counter medicines | Yes No Alcohol                  | Yes No Supplements |
| Yes No Weight loss medications    | Yes No Bisphosphonate (Fosamax) | Yes No Aspirin     |

Please List current medications:

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