Weatherford Pediatric Dental Associates

Brian Westfall, DDS

1508 Ft Worth Hwy, Ste 300
Weatherford, TX 76086
817-594-6364

WELCOME TO OUR PRACTICE!

About Your Child

Patient's Name:____________________________________

Preferred Name:___________________________________

Date of Birth:_______________________ Male or Female

Who is bringing child today? _______________________________________

Who will be financially responsible for this account?________________________________

What are your goals for your child today? ____

How did you hear about our office?

0 Friend (Name)_______________________
0 Drive-By
0 Tooth Fairy School Presentation
0 Tooth Fairy Event or Fair
0 Google or other search engine
0 Other______________________________
0 Other Dentist (Name)___________________
0 Pediatrician (Name)____________________
0 Insurance Referral
0 Our Website
0 Sibling is a Patient already

Medical History

Has your child ever had any of the following conditions?

Y N
0 0 Sickle Cell Anemia or Trait
0 0 Bleeding Disorder or Hemophilia
0 0 Heart Condition (current or repaired)
0 0 Heart Murmur
0 0 Tetralogy of Fallot
0 0 Rheumatic Fever or Scarlet Fever
0 0 Bruises or Bleeds easily
0 0 Asthma or Lung Problems
0 0 Pneumonia (when?________)
0 0 Diabetes (NIDDM or IDDM _____ x day)
0 0 Seizures, Epilepsy, or Convulsions
0 0 Emotional or Behavioral Problems
0 0 Diagnosed with ADD, ADHD or Hyperactivity
0 0 Psychiatric Problems
0 0 Down's Syndrome
0 0 Autistic Spectrum Disorder
0 0 Latex Allergy or Sensitivity
0 0 Speech problems

Y N
0 0 Eye Problem (right or left)
0 0 Hearing Impairment (right or left or both)
0 0 Immunologic Disorder, HIV, AIDS or ARC
0 0 Kidney Disease or Transplant
0 0 Liver Disease or Transplant
0 0 Implanted Shunts, Pins, Screws or Rods
0 0 Cancer, Leukemia, Lymphoma
0 0 Physical or Emotional Abuse
0 0 Cleft Lip/Palate
0 0 Learning Disability
0 0 Congenital Birth Defects/Syndrome
0 0 Tuberculosis or Previous Positive Test
0 0 Delayed Development
0 0 Cerebral Palsy
0 0 Does your child require Antibiotic Pre-medication for dental work?
0 0 Is there a chance that your child is PREGNANT?

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Medical History Continued…

Please list any PAST or CURRENT medical conditions that may affect your child's treatment:
____
____
____

Is the patient currently taking any medication(s)? O Yes O No
If so, for what?____
Is the patient currently under the care of a physician? O Yes O No
If so, for what? ____
Is your child allergic or has your child ever had an adverse reaction to a specific medication, antibiotic or food?
O Yes O No
If so, which one?____
What happened?____

Please list the name and phone number of any treating physicians below:
____

Dental History

Has your child ever suffered from any of the following dental problems?

Y	N		Y	N	
0	0	Bad Breath/Halitosis	0	0	Popping or Soreness of Jaws
0	0	Bleeding Gums	0	0	Dental Infection or Abscess
0	0	Stained or Discolored Teeth	0	0	Pain from Teeth
0	0	Cold Sores or Fever Blisters	0	0	Missing or Extra Teeth
0	0	Dry Mouth	0	0	Injury or Trauma to Teeth, Mouth, or Face

Has your child expressed any dental anxiety or fear? 0 Yes or 0 No ____________________________________
____
Has your child had any bad experiences at another dental office? ____________________________________
How would you describe your child's current oral health? O Excellent O Good O Fair O Poor
What are your primary concerns about your child's oral health? ______________________________________
____

I AGREE THAT ALL OF THE ABOVE MEDICAL HISTORY INFORMATION IS ACCURATE AND CORRECT

*______________________________________ *______________________

Parent/Guardian Signature **Date**

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Person(s) Responsible for Account

Mother's Information: Mother Step Mother Foster Mother Legal Guardian Grandmother

Name:	DOB:	Occupation:
Address:	SS#	Employer:
City, State, Zip:	Marital Status:	Email:
Home Phone:	Cell Phone:	Work Phone:

PLEASE CIRCLE WHICH NUMBER IS BEST FOR CONFIRMING APPTS : HOME CELL WORK

Father's Information: Father Step Father Foster Father Legal Guardian Grandfather

Name:	DOB:	Occupation:
Address:	SS#	Employer:
City, State, Zip:	Marital Status:	Email:
Home Phone:	Cell Phone:	Work Phone:

PLEASE CIRCLE WHICH NUMBER IS BEST FOR CONFIRMING APPTS : HOME CELL WORK

Medical/ Dental Release Statement

I give my consent for Dr. Brian Westfall of Weatherford Pediatric Dental Associates to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Weatherford Pediatric Dental Associates of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Westfall and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Requirement for Filing Insurance Claims; To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. I hereby authorize payment of insurance benefits directly to Weatherford Pediatric Dental Associates. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

*____ *_________________________

Parent/Guardian Signature **Date**

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FINANCIAL AGREEMENT

We appreciate you choosing our office for your child's dental care. At Weatherford Pediatric Dental Associates, we value our relationship with your family and would like to offer the following as our payment policy.

- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and copayments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Weatherford Pediatric Dental Associates.

- In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you , the insured, and your insurance company. If we do not receive payment from your insurance company within 60 days after submission of claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed.

- Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your portion in full at the time of service.

- Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICIES FOR THE OFFICE:

*_____________________________________ *___________________________________

Parent/Guardian Name (**printed**) Parent/Guardian Signature

*_________________________

Date

Weatherford
Pediatric
Dental
Associates

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Dear Parents,

We want you and your child to receive the best possible treatment at our office. We feel this is a joint process in which the parents will play a pivotal role.

The dental treatment area serves multiple functions. We would like to clarify what the treatment areas are used for and how you can maximize the outcome for your child.

Dental offices perform both non-invasive and invasive procedures at the same time in the treatment area. Your child's regular check-ups are considered non-invasive, while dental surgery and operative are considered invasive.

As a parent we know how much time you've spent in your child's physicians office and we, as dentists, share some similarities with them, most notably seeing several patients throughout the day for non-invasive procedures. The most notable difference is that a physician will perform his invasive surgeries in an outpatient setting or at a hospital where only staff and doctors are present. A dentist performs his surgical and operative procedures in the same area and at the same time our non-invasive patients are seen. The dentist requires the same level of concentration given the physician in his controlled environment. Minimum movement and distractions in and about the operative area are crucial for optimum care of the children.

You may choose whether or not to accompany your child to his/her filling appointment. Although we sense some children do better without parents present, we are open to having you present with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

You can assist us by following a few guidelines:

1. Allow us to prepare your child
2. We welcome you to come back to the treatment area for your child's **FIRST NEW PATIENT** visit. On following visits and for all restorative visits, we ask that you allow one of our staff members to stay with your child throughout their entire visit. Unless we make prior arrangements with you, we ask that you wait for your child in our reception area until they are finished with their treatment.
3. **Be supportive of the practice's terminology.**
4. Please be a **SILENT OBSERVER**. That means no talking during dental procedures. Support your child with touches:
   a. This allows us to maintain communication with your child
   b. Children will normally listen to their parents instead of us and may not hear our guidance
   c. You might give incorrect or misleading information
5. If asked to leave, be ready to immediately walk away
   a. Many children will try to control the situation
   b. "Acting out" is normal, but unacceptable during fillings
   c. This is intended to "short circuit" the control attempt
   d. We will continue to support your child at all times

Additional siblings over the age of two in the treatment room present the potential for future dental anxiety to themselves due to possible misinterpretation from a child's perspective.

Following these few simple guidelines will help to insure the best possible results.

I have read the above information and have been explained the office policy on parental presence in the treatment area.

_____________________________________   _______________________________________

Parent/Guardian   Date   Witness   Date

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HIPPA Consent Agreement (Privacy Act)

You may refuse to sign this agreement

I give consent for the Use and Disclosure of Health Information of myself and or my dependent for the purpose of Treatment, Payment, or Communication between other healthcare professionals. I understand and have been provided with a copy of this office's Notice of Privacy Practices that provides a more complete description of health information uses and disclosures. I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing this condensed form.

____
Please Print Name

____
Signature of Parent or Guardian

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign
____Communications barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____Other (Please specify)____

Date:_________________ Staff Signature:____________________________________