west chester
PEDIATRIC DENTISTRY

Bracken Webb, DDS
(513) 777-2313 · Fax (513) 779-5942
9215 Cincinnati-Columbus Rd (Route 42), West Chester, OH 45069
info@brackenwebb.com · WestChesterPediatricDentist.com

Family Information Form - Please complete one per family

Please list names and ages of children in the family _____

_____

Parent/Guardian Information

» **Father/Guardian** Last Name _____ First Name _____ MI ___ SSN _____

Home Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Email _____

Employer _____ Occupation _____

Home Phone _____ Cell _____ Work _____

» **Mother/Guardian** Last Name _____ First Name _____ MI ___ SSN _____

Home Address (☐ same as above) _____

City _____ State _____ Zip Code _____

Date of Birth _____ Email _____

Employer _____ Occupation _____

Home Phone _____ Cell _____ Work _____

Parent's Marital Status _____ Preferred Number To Confirm Appointments _____

Stepfather's Full Name _____ Phone Number _____ Work _____

Stepmother's Full Name _____ Phone Number _____ Work _____

» **Emergency Contact (other than parents)** Name _____

Phone _____ Relationship _____

Whom may we thank for referring you to our practice? (i.e. Name of Friend, Internet, Insurance Website) _____

_____

Dental Insurance Information

Policy Holder's Name _____ Employer _____

Insurance Company _____

Employee ID/SSN _____ Group No. _____

Secondary Dental Insurance

Policy Holder's Name _____ Employer _____

Insurance Company _____

Employee ID/SSN _____ Group No. _____

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Dental & Medical History Form - Please complete one form for each child

Patient Information

Last Name _____ First Name _____ MI ____ Preferred Name _____

☐ Male ☐ Female Birth Date _____ Is your child adopted? Yes No

Father/Guardian name _____ Mother/Guardian name _____

Hobbies/Interests _____

Child's Physician _____ Phone Number _____

Dental History

What is the reason for seeing the dentist? _____

Is this your child's first dental visit? Yes No If no, date of last visit _____

Has child had dental x-rays? Yes No Location _____

Any history of pacifier, thumb sucking or finger sucking? Yes No

Any history of injuries to the mouth or teeth? Yes No

Do any family members have a history of missing teeth? Yes No

Has your child experienced any unfavorable reactions to previous medical or dental care? Yes No

Please circle if your child is having problems with any of the following:

·Cavities ·Toothache ·Grinding Teeth ·Trauma ·Gum Infections ·Sensitive Teeth ·Tooth Color

Is there anything else related to your child's teeth or mouth about which you are concerned? _____

_____

Medical History

Does your child have or have they had any of the following: (circle those that apply)

ADD/ADHD	Diabetes	Heart Condition	Rheumatic Fever
Anxiety	Depression	Hepatitis A, B, or C	Sensory Issues
Asthma	Developmental Delays	HIV/AIDS	Sickle Cell Disease
Autism Spectrum Disorder	Cancer/Tumor	Neurological Disorder	Speech Problem
Bleeding Disorder	Hearing Impairment	Other: _____	

Has your child ever been hospitalized? Yes No If yes, for what reason? _____

Has your child ever had surgery? Yes No If yes, for what reason? _____

Does your child have any allergies? Yes No If yes, what are they? _____

_____

Does your child take any medications? Yes No If yes, please list: _____

_____

Is there anything else about your child that you think we should know in order to provide the best dental care possible? _____

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General Consent for Dental Treatment

Before we begin treating your child, we ask your permission to perform all the dental treatments that are necessary to properly assess your child's oral health, aid in the prevention of future dental problems, and return all teeth and tissues to proper health and function as necessary.

I hereby authorize Dr. Bracken Webb and staff to perform upon my child or legal ward:

(Patient's Name) _____ all necessary dental services he/she may need including one or more of the following procedures:

- cleaning of the teeth and the application of topical fluoride
- advisable radiographs of teeth and jaws (in accordance with ADA guidelines)
- a complete dental examination
- application of plastic sealants to the grooves of the teeth
- use of local anesthesia to numb teeth and tissues
- treatment of diseased or injured oral tissues (hard and/or soft)
- treatment of diseased or injured teeth with dental restorations: composite (white) fillings, stainless steel crowns, prefabricated porcelain crowns, pulpotomies, pulpectomies (nerve treatments)
- removal (extraction) of one or more teeth
- space maintainers and/or habit appliances
- treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
- use of nitrous oxide/oxygen inhalation (laughing gas) as a means of reducing anxiety, raising the pain threshold, and reducing the gag reflex. Risks include nausea and vomiting, occurring in 0.5% of patients.

Our goal is the best oral health for your child, although there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But, ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

I understand that the Doctor and staff will explain the nature and purpose of these procedures. Alternate procedures or methods of treatment, if any, have or will also be explained to me, their advantages and disadvantages, the risks, consequences and probable effectiveness or each, as well as the prognosis if no treatment is provided.

I understand that there is no guarantee that the dental procedures will be successful; however, the procedures are desired and intended to result in improved oral conditions.

I also authorize the Doctor to use photographs, radiographs, other diagnostic material and treatment records for the purpose of teaching, research and scientific publications.

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedure have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Print Parent or Guardian's Name _____ Print Child's Name _____

Parent or Guardian's Signature _____ Date _____

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Financial and Appointment Policies

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment. However, in order to avoid misunderstandings, **please read carefully and understand the following policies in regard to dental insurance benefits.**

Our professional treatment is rendered to your child, not the insurance company. **Your insurance is a contract between you, your employer and your insurance carrier.** We are not a party to that contract.

Our fees are generally considered to fall within the "usual and customary range". Each individual insurance carrier sets their own "usual and customary" fees, and they are not always the same as our fees. Also, please keep in mind that **not all services are covered benefits**.

We will **estimate** your patient portion for treatment based on the information provided by your insurance carrier. If your insurance carrier denies payment or pays less than estimated, you will be responsible for the balance.

We kindly ask that all patient portions, including deductibles, be paid at the time of service. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer on-line bill payment.

Please remember that dental insurance is designed to assist with dental care costs and rarely covers the total cost of services rendered. There may be a deductible, a "co-insurance" factor and a yearly maximum considered.

For divorced households, the parent who brings the child to our office as a patient is responsible for the financial obligations. We will be happy to bill all insurances and provide detailed information for your records. We will also ask that you provide insurance carriers with requested information (court documents, divorce decrees, residence information) as to expedite processing of claims. Claims not processed due to your failure to provide requested information may be closed, and you will be responsible for treatment rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to **contact us promptly for assistance** in the management of your account. All uncollectible accounts are forwarded to our collection agency.

Appointment Policy. Please notify our office at least 48 hours prior to your child's appointment if you have to reschedule. Cancelling your child's appointment in advance allows us to schedule another patient who is in need of our care. We reserve the right to charge a **fee of $35** for the time reserved if you **fail to keep the appointment or cancel with less than 48 hours notice.**

Thank you for reviewing our Financial and Appointment Policies. Please let us know if you have any questions or concerns.

I have read the Financial and Appointment Policies (above). I understand and agree to this Financial Policy and Appointment Policy.

_____ _____

Please Print Name of Responsible Party Please Print Name(s) of Patient(s)

_____ _____

Signature of Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
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)

_____

_____

_____