Welcome To Our Practice!!

We want to welcome your child into our practice. Our goal is to make his/her dental experience pleasant and educational. Please provide us with all information requested so we can better understand and care for your child.

Patient Name: _____ Nickname: _____ Sex:_____
Last First MI

Birthday: _____ Age: _____ Siblings & Ages _____

_____

Home Phone: ( ) _____ School: _____ Grade: _____ Weight: _____

Home Address: _____
Street Apt No.

_____
City State Zip

Email Address*: _____

*(Your email address will be used for the sole purpose of our office contacting you with dental updates and/or newsletters.)

Reason for visit: _____

Has your child had any sickness within the past 2 weeks? YES / NO

Has anyone in the household traveled internationally within the last 30 days? YES/ NO

Health Information - Has your child ever had difficulty with any of the following: (Please check all that apply)

___ADHD	___Cerebral Palsy	___Kidney Disorder	___Respiratory Problems
___AIDS/HIV	___Chicken Pox	___Liver Disorder	___Rheumatic Fever
___Anemia	___Convulsions	___Lung Disease	___Sinus Problems
___Asthma	___Diabetes	___Measles/ Mumps	___Thyroid Disorders
___Autism	___Epilepsy/ Seizures	___Mental Retardation	___Tuberculosis
___Bladder Disease	___Hearing Disorders	___Mononucleosis	___Vision Disorders
___Blood Transfusions	___Heart Condition/ Murmur	___Neurological Disorder	___Behavioral Problems
___Bleeding Disorders	___Hepatitis	___Oral Sensory Disorder	___Emotional Problems
___Cancer	___History of Tumors	___Pregnancy	___Other

Please describe all above conditions that apply: _____

_____

	Yes	No
Is your child in good health?	___	___
Are immunizations up-to-date?	___	___
Is your child taking any medicines or drugs:	___	___
Has your child ever been hospitalized or had surgery?	___	___
Does your child have a heart murmur or condition requiring Prophylactic Antibiotic coverage before dental treatment	___	___
Does your child have any allergies (drugs or latex)	___	___

If yes, please specify:_____

_____

Child's Pediatrician _____ Last Visit:_____ Phone: _____

Has your child been seen by another dentist?_____ If yes, name:_____

Date of last visit:_____ Phone: _____ X-rays: _____

Has your child ever had an unfavorable dental experience?_____

How often does your child brush (i.e. once per day, twice per day): _____

Who is responsible for teeth cleaning? ___Child ___Parent ___Both

Was your child breast fed? _____ Bottle fed?_____ Age discontinued? _____

Does your child: (Please check all that apply)

___Suck thumb/Finger ___Suck/Bite lips ___Grind teeth ___Pacifier

___Bite/Chew nails ___Chew hard objects ___Clench jaw

What is your home water source? ___Public system ___ Private well ___Other _____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate there to. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefits be denied.

Signature of Parent of Guardian:_____ Date:_____

Office Use

I verbally reviewed the medical/dental information above with the parent/guardian regarding the patient named herein. Initials _____ Date _____

Who is Accompanying the Child today?

Name:_____ Relationship:_____
Do you have legal custody of this child?_____ Is your child adopted?_____
Child lives with: ___Both parents ____Mom ____Dad ____Grandparent ____Guardian

I have listed below two persons who might be involved in his/her dental updates and/or transportation.

1. _____ 2. _____

Parent (or Guardian) Information

Father's Name: _____
DOB: _____
Soc. Sec. #_____
Home address if different from child:
_____
_____
Home #: _____
Work #: _____
Cell #:_____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married
___Divorced ___Widowed

Mother's Name: _____
DOB:_____
Soc. Sec. #_____
Home address if different from child:
_____
_____
Home #: _____
Work #:_____
Cell #:_____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married
___Divorced ___Widowed

Emergency Information

Name_____ Relationship_____ Phone_____

Person Responsible for Account

Name:_____ Relationship:_____
Billing address_____
Home phone _____ Work _____ Cell _____
DL#_____ SS#_____
Email Address*: _____
*(Your email address will be used for the sole purpose of our office contacting you with dental updates and/or newsletters.)

Primary Insurance Information

Name of Insured:_____
Insured Date of Birth:_____ ID No._____Group No._____
Insured's address_____
Insured's Employer Name_____
Employer address_____
Patients relationship to insured: ___self ___Spouse ___Child ___ Other_____
Insurance plan name_____ phone _____
Insurance plan address_____

Referral Information – who can we thank for referring you to our office?

___another patient ___dental office ___ pediatrician ___ yellow pages ___website ___newspaper ___school ___work
___other_____ Name of office referring you to our practice _____

I authorize the dentist to release any information to third party payers and /or other health practitioners, if necessary. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

Signed: _____ Date: _____

PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State Law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand.

I hereby authorize Dr. Gretchen M. Jetton assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon my child (or legal guardian) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-ray), or diagnostic aids.

In general terms the dental procedure(s) or operation will include:

A. Cleaning of the teeth and the application of topical fluoride
B. Application of plastic "sealants" to the grooves of teeth
C. Treatment of diseases or injured teeth with dental restorations (fillings or crowns)
D. Use of local anesthetic to numb treatment area
E. Replacement of missing teeth with dental prosthesis – pedi-partial, space maintainer
F. Removal (extraction) of one or more teeth: primary/permanent
G. Impression for appliance
H. Treatment of diseased pulp: pulpotomy/pulpectomy
I. Use of physical restraint or restraining devices to safely complete necessary dental procedures
J. Use of sedative drugs to control apprehension and/or disruptive behavior
K. Use of IV anesthesia to accomplish the necessary treatment
L. Use of nitrous oxide to accomplish the necessary treatment
M. Other:_____

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I am advised that, though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to a cure. I further authorize the doctor to perform other dental services that, in his/her judgement, are advisable for my child or legal guardian, with the exception of (if none so state) _____

Although their occurrence is extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia or sedation. State Law requires us to mention the risks of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept the complications may require hospitalization and may even result in death.

I also authorize Dr. Gretchen Jetton to use photographs, radiographs, other diagnostic materials, 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 the procedure or procedures have been answered in a satisfactory manner; and I understand that I have the right to be provided with answers to questions which 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 chose to terminate it.

Patient's Name: _____ Date:_____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please print name Date

Signature

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barriers prevented us from obtaining acknowledgement

_____ Emergency situation prevented use from obtaining the acknowledgement

_____ Other (please specify) _____

Financial Policy

We are pleased to welcome you to our practice. Our goal is to provide your child with the highest quality dental care and to create caring relationships in a compassionate and friendly atmosphere. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

Full payment is due at the time of service. *(See Insurance Section Below)*
We accept checks, debit cards, and credit cards (Visa, MasterCard)
We offer Care Credit extended payment plans with no interest upon approved credit.

Insurance
Your insurance policy is a contract between you and your insurance company. Please know that your insurance benefits are determined by you and your employer, and we are not a party to this contract. We will file your primary dental insurance claims as a courtesy to you. Please be aware that some, and perhaps all of the services provided on your behalf, may be non-covered services and not considered reasonable and necessary under some insurance plans. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. If your insurance company requires a referral or preauthorization, you are responsible for obtaining it. We do require deductibles and patient portions to be paid at the time services are rendered. The balance is your responsibility whether or not your insurance company pays.

Finance Charges
By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. We will be glad to send a refund to you if your insurance pays us. After 90 days, the account will be considered past due. At this point, we will refer your account to IC System Collection Agency and an additional 33% will be added to your account balance to cover all costs and expenses, including all reasonable attorney fees, for this service.

Minors
The person bringing the child to their appointment is financially responsible for all services rendered unless arrangements prior to the appointment have been made.

Missed Appointments
Appointment times are reserved just for you. Please help us serve you better by keeping your scheduled appointments. Unless rescheduled at least 24 hours in advance, our policy is to charge a $50.00 "No Show Fee". For scheduled sedation appointments, a $50.00 "No Show Fee" will be assessed to the account. Excessive missed appointments may result in being asked to seek dental services elsewhere.

Emergency Appointments
If a child is seen for an emergency after our regular business hours, an "after hours" fee is charged in addition to any services rendered at that visit. All emergency treatment must be paid in full at the time of service.

Returned Checks
There is a fee of $30.00 for any check returned by the bank.

Divorce
The responsible party prior to a divorce or separation will remain responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

Effective Date
Once this document is signed, you agree to all terms and conditions and the agreement will be in full force and effect.

_____ _____
Name of Patient Date

_____ _____
Parent or Responsible Party (Printed) Date

_____ _____
Signature of Parent or Responsible Party Date

Dentistry for Children
17320 West Grand Parkway South, Suite D
Sugar Land TX 77479

Gretchen M. Jetton, DDS
Dentistry for Children
promoting healthy smiles from infancy to adolescence

CONSENT FORM FOR TAKING YOUR CHILD'S PHOTO TO BE PLACED IN THE PATIENT CHART FOR THE OFFICE OF JETTON DENTISTRY FOR CHILDREN

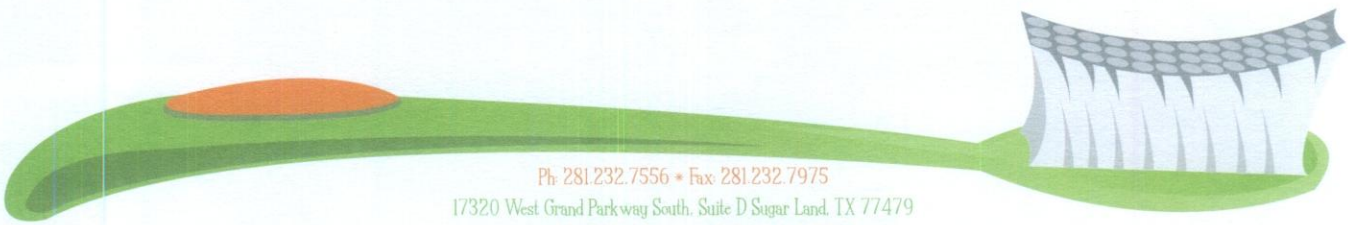
As the parent/guardian of _____, I give my permission for my child's photo to be used in the patient chart.

This picture will only be used for INTERNAL RECORDS. I can request that my child's picture be removed from the chart at any time.

Signed Permission will be kept as part of your child's medical record.

_____ _____

Parent/ Guardian Signature Date



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