William L. Whatley, D.M.D., P.C.

Practice Limited to Pediatric Dentistry

WELCOME

I look forward to meeting you and your child at your first visit to my office. As a pediatric dentist, my office routine may be somewhat different than you have been accustomed to in the past. To have you and your child feel more at home, I would like to take a few minutes to familiarize you with my practice.

One of my prime objectives is to make your child a good dental patient, who will be able to accept routine dental treatment. Listed below are some suggestions to guide you.

1. Dental visits are a part of growing up. Please don't indicate in any way that there is anything to fear.

2. The less "fuss", the better. It is best to tell your child about the dental visit the day of the appointment.

3. If your child requires more information, you can explain that the doctor will look at his teeth to make sure that they are healthy.

4. Make appointment days easy and try to see that your child is well rested.

5. Don't threaten a visit to the dentist as punishment for misbehavior.

6. Remember, tears are a healthy avenue of expression for a child when moving toward the unknown, so please don't be disturbed or embarassed if your child cries. Once a child becomes familiar with the new dental surroundings, the fear will disappear.

At the first visit, the child is acquainted with the office and with our staff. A thorough examination, which includes a clinical exam and necessary x-rays will be performed on the first visit. Everything that we intend to do is shown to the child before we do it.

We welcome the parent in the treatment room with the child for the initial exam and check up appointments. When other treatments are being performed, we require children enter the treatment room escorted by an assistant without the parents.

If more than one person is talking or directing, the child tends to become confused. Naturally we do not want this to happen. We have found that children relax, listen, and communicate more effectively with Dr. Whatley when parents are not in the room with them.

After the x-rays and examination have been interpreted, your child's oral health proposed treatment plan and financial arrangements will be discussed with you. Please feel free to ask any questions that you may have.

My office is committed to a policy of prevention. By seeing your child early in life, we can prevent dental decay and infections by early treatment, oral hygiene therapy and diet counseling. Orthodontic problems may also be prevented or the severity lessened by early recognition and treatment.

Your child, with your cooperation, can become an excellent dental patient with a healthy mouth and pretty smile.

Payment is expected in full for the first visit. If you have dental insurance, we will be happy to process your forms. You are responsible for any charges not covered by your insurance carrier and any charges that remain unpaid after 30 days.

My staff and I make every effort to be on time for your child's appointment; however, because we are a pediatric practice, sometimes extra time may be required for a child's treatment. We feel it is important to spend this extra time if needed to assure the best dental experience possible.

We have a long waiting list for children who need appointments, so please be sure to attend your reserved appointment time. Broken appointments will result in dismissal from our office. If you are late for your appointment all planned treatment may not be performed at that time or your appointment may be rescheduled. Thank you for your consideration with this matter.

Cordially yours,

- William L. Whatley D.M.D., P.C.

I have read the above and have had the opportunity to ask any questions.

Signature _____ Date _____

William L. Whatley, D.M.D., P.C.

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SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office.

SOCIAL HISTORY

Child's name _____ Birthdate _____ Grade _____

By what name does your child prefer to be called? _____ School _____

Brothers _____ Sisters _____ Hobbies & Pets _____

Mailing Address _____ Home Telephone _____

City _____ State _____ Zip _____ E-mail Address _____

Father's name _____ SS# _____ D.O.B. _____

Employer _____ Business Telephone _____

Mother's name _____ SS# _____ D.O.B. _____

Employer _____ Business Telephone _____

Do mother, father, and child live together? _____ If not, with whom does the child live? _____

Do you have dental insurance? _____ Policy # _____

Insured's name _____

Insurance Company's name _____ Insured's D.O.B. _____

Whom may we thank for your referral to our office? _____

Has our office rendered treatment to any other family members? _____

Please list names _____

MEDICAL HISTORY

Condition of the child's general health _____ Height _____ Weight _____

Child's physician _____ Address _____ Telephone # _____

___ Yes ___ No Are your child's immunizations up to date? If no, explain _____

___ Yes ___ No Does your child have physical or mental disabilities? If yes, explain _____

___ Yes ___ No Has your child ever been hospitalized? Date _____ Reason _____

___ Yes ___ No Has your child ever had a blood transfusion? Date _____ Reason _____

___ Yes ___ No Has your child received emergency medical treatment within the last six months? If yes, explain _____

___ Yes ___ No Has your child ever had hearing, sight, speech or learning problems? _____

___ Yes ___ No Is your child currently receiving speech therapy? If yes, by whom? _____

- OVER -

___ Yes ___ No Has your child ever received injuries to the head, jaw, mouth or teeth? If yes, describe _____

_____

___ Yes ___ No Is your child allergic to any medicine or food? If yes, what _____

_____

___ Yes ___ No Is your child taking any medicine now? If yes, what _____

_____

How long since your child's last physical examination? _____

How long since his/her last tetanus shot? _____

Indicate any of your child's past or present conditions:

___ Yes ___ No Anemia	___ Yes ___ No Epilepsy	___ Yes ___ No Muscle Disorders
___ Yes ___ No Asthma	___ Yes ___ No Eye Disorders	___ Yes ___ No Nose / Throat Disorders
___ Yes ___ No AIDS	___ Yes ___ No Heart Condition / Murmur	___ Yes ___ No Rheumatic Fever
___ Yes ___ No Bleeding Tendency	___ Yes ___ No Hemophilia	___ Yes ___ No Skin Disease
___ Yes ___ No Blood Disease	___ Yes ___ No Hepatitis	___ Yes ___ No Sickle-Cell Anemia
___ Yes ___ No Bone Disorders	___ Yes ___ No High Blood Pressure	___ Yes ___ No Stomach Problems
___ Yes ___ No Convulsions	___ Yes ___ No Hyperactivity	___ Yes ___ No Tumors
___ Yes ___ No Diabetes	___ Yes ___ No Kidney Disease	___ Yes ___ No Tuberculosis
___ Yes ___ No Ear Disorders	___ Yes ___ No Liver Disease / Jaundice	___ Yes ___ No Other _____
___ Yes ___ No Emotional Problems	___ Yes ___ No Lung Disease	_____
___ Yes ___ No Endocrine Disorders	___ Yes ___ No Mental Retardation	_____

DENTAL HISTORY

Date of last dental visit _____ Dentist _____

At what age did your child stop using a nursing bottle? _____ Does your family drink well or city water? _____

How often are your child's teeth brushed per day? _____ By whom? _____

___ Yes ___ No Has your child experienced any unfavorable reactions from previous dental or medical care? If yes, explain _____

_____

___ Yes ___ No Has your child had a toothache recently? If yes, explain _____

_____

___ Yes ___ No Has your child received trauma to his/her teeth? If yes, explain _____

_____

___ Yes ___ No Does your child ever have popping, clicking or pain in the jaw joint? _____

___ Yes ___ No Does your child have any history of mouth breathing, thumb sucking, finger sucking, lip/nail biting or other habits? If yes, please underline.

___ Yes ___ No Is your child taking any vitamins or fluorides?

___ Yes ___ No Does your child have a dental condition about which you are especially concerned? If yes, explain _____

_____

___ Yes ___ No Is there anything else about your child that you think I should know in order to better plan his/her dental treatment?

If yes, explain _____

_____

CONSENT

I acknowledge that the above information is correct and authorize Dr. William Whatley and staff to provide dental treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostic radiographs and photographs. I also understand that payment is expected as services are rendered.

Method of payment: ☐ Check ☐ Cash ☐ Credit Card

Parent or Legal Guardian _____ Date _____

William L. Whatley, D.M.D., P.C.

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POLICY FOR FILING INSURANCE CLAIMS

As a courtesy to our insured patients, our office will file dental claims with your primary dental insurance company. All claims are submitted electronically by our office though an electronic claims vendor. It is essential you provide us the proper insurance information at each appointment and alert us to any change in coverage. You will be responsible for paying any deductibles and our estimated co-payment for that day's dental treatment. If your insurance company does not accept assignment of benefits, full payment for services will be required at the time of service.

If your child requires sedation, we will require full payment of the sedation fee in advance of the appointment. We are unable to file insurance claims for sedation since Dr. Whatley does not provide the sedation service. We will provide paperwork so that you may file a claim for sedation charges.

The state of Georgia requires that insurance companies pay claims within 15 working days of receiving the claim. Unfortunately, this law is commonly ignored by insurance carriers.

We will await payment by your insurance company for 30 days from the date of service. If payment is not received within 30 days, then you are responsible for full payment for treatment performed on that date of service. If payment is received from your carrier after you make payment, we will issue a check reimbursing you.

I understand that payment of my account is my responsibility if my insurance company fails to pay for any reason. I have read and understand the above and agree to pay any balance due not paid by my insurance carrier within 30 days.

Signature _____ Date _____

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