Silvestro Iommazzo, D.D.S.

Dentistry for Children and Adolescents

1212 East Putnam Avenue
Greenwich, CT 06878
203-698-0794

Dear Parent:

We welcome this opportunity to examine and to assist with the oral health needs of your child. In this letter we shall try to answer certain questions that most parents ask, and to acquaint you with some of our office policies. Of course, we will be glad to answer your individual questions at any time.

1. Have you any suggestions about how to prepare my child for his/her first visit?

The most important thing is NOT to overprepare your child. Casually mention a few days ahead that "we are going to visit the dentist the day after tomorrow". If your child has any questions, answer them briefly and enthusiastically. Be positive in your approach. Tell your child we will count and take pictures of his/her teeth and that we will show him/her (and you) how to clean his/her teeth.

2. What is the procedure at the first visit?

At the first visit your child is introduced to our dental office. His/her teeth and supporting structures will be thoroughly examined and the bite will be evaluated. Only those x-rays that are absolutely necessary will be taken, our office policy is to keep radiation exposure to an absolute minimum. In most circumstances we will then provide a dental cleaning and topical fluoride treatment to aid your child in his "fight against tooth decay".

If you have an emergency appointment because your child is in pain, the emergency will be taken care of immediately, and the regular routines left for another time.

3. May I come into the treatment room with my child?

Frequently we shall request a parent to accompany the child into the treatment room for the first or "introductory" visits. The parents presence is often comforting and reassuring in a new situation. If the parent desires, they may accompany the child at subsequent visits, but since we must devote full attention to your child and he/she to us, we may ask you to return to the reception room. Please be assured we will always treat your child as we would our own.

4. What is your philosophy of treatment?

Our emphasis is on prevention and early treatment. We will devote attention to showing you and your child how to control cavities and gum disease through home hygiene and dietary control. The primary teeth form the basis for a healthy adult dentition. We will do everything possible to correct any dental problems your child may have. Your aim, as a parent and mine as a pedodontist, are the same – to keep your child's teeth in good condition and to make the process of doing so a pleasant one.

P.S. Please complete health questionnaire which should be brought to first appointment. Please review carefully the office policy regarding dental insurance, payments and appointments.

Date _____

Child's Name _____ Nickname _____

Date of Birth _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

PARENT INFORMATION

Father's Full Name _____ Social Sec.# _____

Employed By _____

Business Address _____

Occupation _____ Telephone # _____

Dental Insurance Carrier _____

Mother's Full Name _____ Social Sec.# _____

Employed By _____

Business Address _____

Occupation _____ Telephone # _____

Dental Insurance Carrier _____

CHILD'S HEALTH HISTORY

Reason for Dental Visit _____

Family Dentist _____

Child's Previous Dentist _____

Date of Last Dental Visit _____

Has there ever been a problem with previous dental care? _____

If so, please explain _____

_____

Does your home have city water supply or well water? _____

Does your child take fluoride supplements? _____

Does your child have a habit, such as thumb sucking or use of a pacifier, that may effect his teeth? _____

Name of Child's Physician _____

Your child's health is: ❑ Excellent ❑ Fair ❑ Poor

Is your child taking medication at the present time? _____

If so, what type of medication? _____

Does your child have any of the following:

Heart Murmur	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Kidney or Liver Problems	❑ Yes	❑ No
Allergies	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Bleeding Problems	❑ Yes	❑ No
Seizure Disorder	❑ Yes	❑ No
Handicap or Emotional Problem	❑ Yes	❑ No

Any other pertinent medical information? _____

Has your child ever been hospitalized? _____ If so, please explain _____

_____

Have you ever been warned against giving your child any type of medicine? _____

If so, please explain _____

CHILD'S TEMPERAMENT

❑ Shy ❑ Fearful ❑ Requires special understanding

❑ Easygoing ❑ Calm ❑ Outgoing ❑ Manipulative

How do you think your child will act during dental treatment? _____

Is there anything else you would like us to know about your child? _____

OTHER INFORMATION

Names and ages of brothers and sisters: _____

_____

Hobbies, Pets, Favorite T.V. Shows, etc. _____

Is there someone we should thank for referring your child? _____

Name _____

Address _____ Tel.# _____

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OFFICE POLICIES

INFECTION CONTROL: Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

PAYMENT: Payment is due at time of service. For your convenience we also accept MasterCard and VISA.

INSURANCE: OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU NOT TO THE INSURANCE COMPANY, therefore we do not accept insurance as payment. Only in this manner can we achieve the best interpersonal relationship and optimum treatment required. In extenuating circumstances, for example; extensive treatment, prior arrangements utilizing insurance can be discussed with the Doctor.

A 'super bill' will be provided at time of payment that can be attached to your insurance form for direct reimbursement from your insurance company to you. All necessary information required by insurance companies is provided on this form.

APPOINTMENTS: An appointment charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still have to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

To the best of my knowledge the information provided is accurate, complete and understood. I authorize Dr. Silvestro Iommazzo and/or his staff to provide dental treatment, and I AGREE TO BE TOTALLY RESPONSIBLE FOR PAYMENT OF EXPENSES INCURRED IN THAT CARE AT TIME OF SERVICE.

Signature _____

Relationship _____