WELCOME TO PEDIATRIC DENTISTRY
Robin G. Stratmann, DDS, PC

We would like to take this opportunity to welcome your family as well as introduce our practice benefits and guidelines.

Robin G. Stratmann, DDS, MS, Pediatric Dentist

Dr. Robin Stratmann received her Bachelor of Science degree from Louisiana State University in 1978 and her Doctorate of Dental Surgery from University of Texas Dental Branch Houston in 1982. After several years practicing general dentistry, she returned to school and received her post graduate certificate in Pediatric Dentistry in 1987. Dr. Stratmann is currently board certified as a Diplomate of the American Board of Pediatric Dentistry and promotes the highest standards of the dental specialty. In addition to her private practice, Dr. Stratmann has served as a clinical assistant professor in the graduate program of pediatric dentistry at the University of Texas Dental Branch (UTDB). Dr. Stratmann holds courtesy staff privileges at Texas Children's Hospital, Herman Hospital and Northeast Medical Center and has been recognized in Texas monthly Magazine as determined by her peers and colleagues as one of the *Best Dentists in America* in 2005 and 2006.

Robin G. Stratmann, DDS, MS, Orthodontist

Dr. Stratmann received a Masters of Science degree in Orthodontics from the University of Texas Dental Branch Houston in 2001. In her capacity as a clinical assistant professor at UTDB in the Department of Pediatric Dentistry, Dr. Stratmann was instrumental in developing the clinical orthodontic training material in the areas of early growth and development and interceptive orthodontics. These two areas of orthodontic sub-specialization are keen areas of interest to Dr. Stratmann and are best applied in her pediatric office environment. She is board certified as a Diplomate by the American Board of Orthodontics and is a member of both the American Association and Southwest Society of Orthodontists. Dr. Stratmann's dual board certification makes her uniquely qualified to meet the needs of your children and teens.

Services

- Treatment visits with reserved time exclusively for your child and the Doctor
- Treatment care options available including sedation appointments and hospital cases
- Emergency care
- Plaque scoring at all prevention visits
- ***"Dollie"*** the dolphin educational programs
- Early interceptive orthodontics
- Complimentary water testing for fluoride levels
- Orthodontic treatment by a specialist in orthodontics

Benefits

- Equipment and office specifically designed for children promoting comfort and a positive experience
- Specialized training in care of infants, children, and teens
- Growth and development monitoring at every visit
- Advanced training and experience in providing care in unique situations
- Training in the care of children and behavior management techniques
- Options for the child's comfort and safety during treatment, including sedation
- Advanced training in CPR, nitrous oxide, and infection control
- Infant oral care training for parents with children under the age of two

Guidelines

- Please respect all our families by arriving on time for your visit
- If it is necessary to change an appointment, 48 business hours notice is required
- Follow the guidelines of our cancellation policy to ensure all our families are treated fairly
- If a change in address or telephone numbers is necessary, please contact the office promptly
- All fees for services are due at the time of the visit unless financial arrangements have been made previously
- If your treatment option is sedation for your child, please read and follow the pre-sedation orders and post operative instructions
- If your child has a dental emergency, call the office immediately
- Our policy of no food or drinks is due to the fact our sedation patients must refrain for 12 hours

Your family's comfort, safety, and care is our focus. We know creating good communication will promote and enhance our relationship. Therefore, we invite you to review this information with our staff. We realize you have a choice in selecting your dental health care provider and we appreciate the opportunity you have given us in caring for your most precious possessions.

I acknowledge that I have read and agree to follow the guidelines listed above.

_____ _____

Signature **Date**

ORAL HEALTH FORM

We welcome your child into our practice and we will try to make his/her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Child's Name _____

What is your child called(nickname) _____ Date of Birth _____ Current Weight _____

Name and Age of Brothers and Sister _____

Child's Physician or Pediatrician _____

Physician's Phone _____ Family Dentist _____

Dental Insurance: Yes _____ No _____ Name of Insurance Company _____

Who may we thank for referring you to our office? _____

Name and kind of child's favorite pet, toy, hobby or sport activity? _____

What is your chief complaint, if any, about your child's mouth or teeth? _____

HEALTH HISTORY

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING(Please check):

___ Anemia	___ Chicken Pox	___ Hepatitis	___ Mental Retardation	___ Tuberculosis
___ Asthma	___ Convulsions	___ Kidney Disorders	___ Mononucleosis	___ Vision Disorders
___ Bladder Disease	___ Diabetes	___ Liver Disease	___ Mumps	___ Blood Transfusions
___ Blood Disorders	___ Epilepsy	___ Lung Disease	___ Rheumatic Fever	___ Other
___ Bleeding Disorders	___ Hearing Disorders	___ Malignancies	___ Sinus Problems	
___ Cerebral Palsy	___ Heart Disorders	___ Measles	___ Thyroid Disorders	

	Yes	No
1. Is your child in good health?	____	____
2. Is your child under the care of a physician now? for illness or injury?	____	____
3. Has your child had an unexplained weight loss in the last 12 months?	____	____
4. Is your child taking any medicine or drugs?	____	____
If so, what? _____		
5. Does your child have any swollen glands or lymph nodes?	____	____
6. Is there excessive bleeding when cut?	____	____
7. Has your child ever been hospitalized?	____	____
8. Has your child ever had surgery?	____	____
9. Is there any allergy or unfavorable reaction to antibiotics (e.g. penicillin), local anesthetics or other drugs?	____	____
If so, please specify _____		
10. Are there other allergies: food, pollen, animals, dust or other?	____	____

11. Current immunizations:

____ DPT #1 (2 mo.)	____ DPT #3 (6 mo.)	____ Polio (2 mo.)	____ Measles,mumps,
____ DPT #2 (4 mo.)	____ DPT #4 (15 mo.)	____ Polio (18 mo.)	rubella (15 mo.)

12. Is there any other information I should be aware of that is not mentioned above?	____	____

Please describe _____

_____

_____

DENTAL AND FAMILY HISTORY

	Yes	No
1. Has your child any history of nail biting, thumbsucking, fingersucking, mouth breathing, teeth grinding or did he/she use a pacifier past age 1 1/2 years? (Underline condition)	____	____
Is this a currently active habit?	____	____

(Continued on Reverse)

	Yes	No
2. Does your child have or has he/she had frequent ear and throat infections or tubes in ears?.....	____	____
3. Has your child any history of hearing loss or speech problems?.....	____	____
(Underline and explain)_____		
4. Has mother or father had a lot of tooth decay?.....	____	____
5. In your family is there any history of malocclusions, bad bites, missing or extra teeth?.....	____	____
(Underline and explain)_____		
6. Has your child had a toothache recently?.....	____	____
7. Is your child in pain now?.....	____	____
8. Do you think there is anything wrong with his/her teeth, such as a chipped or decayed tooth, gum boil, etc.	____	____
Explain _____		
9. Has your child had previous dental treatment?.....	____	____
When and where?_____		
10. Do mother and father and child live together? If no, please explain _____	____	____
11. Is your child adopted?	____	____
12. If you have previously completed this form for another child, please give that child's name _____		

PREVENTIVE ASSESSMENT

Tooth Cleaning

Frequency. Times per day ____ When? _____
Type of Toothbrush _____
Dental Floss ____ Yes ____ No
Disclosing Tablets ____ Yes ____ No
Who is responsible for tooth cleaning? __ Parent __ Child __ Both
Have you received instruction in tooth cleaning? ___ Yes ___ No

Fluoride Inventory

Water fluoridation __ Yes __ No __ Unsure
Fluoride Supplements __ Yes __ No
If Yes to above, what kind?_____
Fluoride Rinse __ Yes __ No
Fluoride Toothpaste __ Yes __ No

Father/Guardian Name_____ Mother Name_____
Tx Driver Lic.#_____ Birthdate_____ Tx Driver Lic.#_____ Birthdate_____
Soc. Sec.#_____ Phone #_____ Soc. Sec.#_____ Phone #_____
Home Address_____ Home Address_____
_____ _____
Mailing Address if Different from home address_____
Father Employed By_____ How Long?_____
IF SELF. STATE BUSINESS NAME
Occupation_____
Business Address_____ Phone_____
STREET CITY STATE ZIP CODE
Mother Employed By_____ How Long?_____
IF SELF. STATE BUSINESS NAME
Business Address_____ Phone_____
STREET CITY STATE ZIP CODE
In case of emergency - name of nearest relative or friend_____ Phone_____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any/or all necessary dental treatment is performed.

Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorizes the dentist to render necessary dental treatment, to administer anesthetics, to administer medications, to take radiographs (X-Rays), clinical photographs, study models and other records necessary for an accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and to employ such assistance as is appropriate.

The undersigned also agrees to be responsible for any bill incurred on this child for dental treatment.

Date_____ Signature_____

Pediatric Dentistry, Robin G. Stratmann, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices as the personal representative/parent of the following patients.

Please Print Name

Signature

Date

Patient Name 1

Patient Name 2

Patient Name 3

Patient Name 4

Patient Name 5

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/Responsible Party refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

INFORMED CONSENT

Our pediatric dental office philosophy is based on our commitment to preventive dentistry and to creating a supporting and nurturing environment for the children and young adults under our dental care. In particular, we are dedicated to providing safe, comfortable, and quality dental treatment for all of our patients.

We are required to obtain your informed consent before we can provide any dental services for your child. Our most important general office policy is to "inform before we perform". Specifically, we are requesting your permission for the following diagnostic and preventive dental procedures: comprehensive clinical examination, selected diagnostic x-rays, thorough professional cleaning and decay-fighting fluoride treatment.

If dental treatment is necessary, we require your consent for a number of additional procedures which include, but are not limited to, the following: local anesthesia ("novocaine", actually "lidocaine"), low-level nitrous oxide-oxygen sedation ("laughing gas"), and dental restorations. A comfortable mouth prop ("tooth pillow"), extensive use of the classic "tell-show-do" method, modeling and voice control may also be used to introduce new methods and materials to your child. Unless specifically invited by a doctor, parents, guardians and other caretakers are requested to remain in our reception area during your child's dental appointment.

We would like to stress the importance of arriving on time for your appointment. If you are unable to arrive on time or at all for an appointment, please notify us as far in advance as you can.

Please feel free to ask any questions you may have regarding the preceding information or concerning any other aspect of our dental practice or your child's dental treatment.

Thank you for taking the time to read and sign this important document.

_____	_____
PRINT PATIENT'S NAME	YOUR SIGNATURE
_____	_____
PATIENT'S AGE	PRINT YOUR NAME
_____	_____
WITNESS' SIGNATURE	YOUR RELATIONSHIP TO PATIENT
_____	
TODAY'S DATE	

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_____	
TODAY'S DATE	

PEDIATRIC DENTISTRY,
ROBIN G. STRATMANN, DDS, MS, PC
9802 FM 1960 Bypass, Suite 270
Humble, Texas 77338
281-446-0456

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to us. Please ask if you have any questions about our fees, our Financial Policy or your responsibilities under this policy.

- Full payment is due at the time of service unless prior arrangements have been made
- These prior arrangements, like insurance assignment, do not relieve you from total responsibility for the cost of dental services provided
- We accept cash, checks and major credit cards

For your convenience, we will file your insurance forms at **no charge** to you. However, dental insurance plans vary widely and we feel you should be aware of these dental insurance misconceptions:

Fact #1 Dental insurance is not meant to pay-all; it is only meant to be an aid to offset the total cost for these services.

Fact #2 Many plans tell the insured that they will be covered "up to 80 or 100%." In spite of what you are told, we have found most plans cover about 50 to 60% of an average fee. Some plans pay more, some less. The amount your plan pays is determined by how much your employer paid for the plan. The less paid for the insurance, the less you receive.

Fact #3 It has been the experience of many Dentists that some insurance companies tell their customers that the charged "fees are above the usual and customary" rather than saying their benefits are low for the dental service performed. Remember, you get back only what your employer puts in less the profits of the insurance company.

Fact #4 Many routine dental services are **NOT** covered by insurance carriers.

We will work to assure that you receive the insurance benefits to which you are entitled under your plan; however, you also have an obligation to monitor your own insurance benefits and to participate in this process. Regardless of the reason, if the insurance company fails to pay the Doctor within sixty days of the date treatment was rendered, all fees are due and payable at that time.

Please Note: Our office appreciates those patients who honor their scheduled appointment times. We do assess a $35.00 fee to those patients that cancel without 48 hours notice, as this chair time has been reserved and cannot be filled in such short notice.

_____ _____

Signature Date