Michael A. Worman, D.D.S.
Sandra A. Worman, D.D.S.
Marai Vales, D.M.D.
Pediatric Dentistry

Gerald Francati, D.D.S.
Orthodontics

5353 - 1st Avenue South
St. Petersburg, FL 33707
727-321-6911

Michael A. Worman, D.D.S., P.A.
Pediatric Dentistry

In Case of Emergency
392-3341 or 548-9555

Welcome to our office. We are proud that you have selected us to assist you with the oral health needs of your child. We are devoted to making your visits as comfortable as possible. Our goal is for children to reach adulthood with all their teeth, as few cavities and fillings as possible, proper bites and a positive feeling for dentistry.

At the first appointment, your child will go to the examination area with my dental assistant, after she has conferred with you. We will take necessary radiographs, check for decay and the location and position of unerupted permanent teeth. We will evaluate the way your child's teeth come together, see if there is enough room for the permanent teeth, and if childhood habits, like thumbsucking and tongue thrusting, have caused any harm to the teeth and jaws. Your child's teeth will be cleaned and topical fluoride applied. I will then consult with you to inform you of the health of the mouth and any of my recommendations. I will also be happy to answer any questions or concerns you have.

Upon completion of the recommended treatment, we will see your child at regular intervals for dental health check ups. These important appointments keep our patients healthier, happier and actually looking forward to their visits.

For your convenience, please fill out the enclosed health history and bring it to your next appointment.

We look forward to seeing you.

Michael A. Worman, D.D.S.

Sandra A. Worman, D.D.S.

Worman & Worman

Pediatric Dentistry

PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Date _____ Patient Social Security Number _____

Patient's Name _____ Nickname _____

Age _____ Date of Birth _____ Sex _____ Race _____ School _____ Grade _____

Parents or Responsible Guardian _____ Telephone: Home _____ Cell M _____

Address _____ Cell D _____

Number and Street City State Zip

Name of Child's Physician _____ Date last seen _____

Address _____ Telephone _____

Brothers and Sisters (List by name and age please)

_____ _____

_____ _____

_____ _____

Father's Name _____ Mother's Name _____

Home Address _____

Number and Street City State Zip

Home Phone _____ Former Address _____

Number and Street City State Zip

Father's Occupation _____ SSN _____ Business Phone _____

Name of Employer _____ City _____

Mother's Occupation _____ SSN _____ Business Phone _____

Name of Employer _____ City _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan? ☐ Yes ☐ No
   Name of parent insured _____ Social Security No. _____
   Name of Insurance _____ Group No. or Policy No. _____
   Has your child received previous dental care under this plan? ☐ Yes ☐ No
2. How did you first hear about our practice? _____
3. Is your child in pain, or have an emergency dental condition? ☐ Yes ☐ No
   If no, reason for bringing child to the dentist at this time _____

HISTORY

	Yes	No
1. Is your child in good health?	☐	☐
If No, what is the reason? _____		
2. Is your child being treated by a physician at this time?	☐	☐
If Yes, why _____		
3. Has your child ever been a patient in a hospital?	☐	☐
If Yes, why _____		
4. Has your child ever received general anesthesia or sedation?	☐	☐
If Yes, why _____		
5. Is your child allergic to anything? (medicine, food)	☐	☐
If Yes, what _____		
6. Is your child taking any medication at this time?	☐	☐
If Yes, what _____	☐	☐
7. Has your child ever had a blood transfusion?	☐	☐
8. Has your child ever been seen by a dentist before?	☐	☐
Date last seen _____ Name of dentist _____		
9. Has your child ever received fluoride in any form?	☐	☐
10. Does your child suck his/her thumb or fingers?	☐	☐
11. Are your child's teeth brushed and flossed once or more a day?	☐	☐
12. Has your child had any unfavorable medical or dental experience?	☐	☐
If Yes, please explain _____		

REVIEWER COMMENTS

ORGAN SYSTEMS

Has this child ever had any treatment of any of the following? Please check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Hearing	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check Yes or No and explain below in comments section.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Eye Problems	☐	☐	Polio
☐	☐	Anemia	☐	☐	Excessive Bleeding Problem	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hepatitis - Type_____	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	HIV	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats - Frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Speech Problems
☐	☐	Cleft Lip/Palate	☐	☐	Mental Retardation	☐	☐	Spina Bifida
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Syndrome_____
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Tetanus
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Tuberculosis
☐	☐	Drug or Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Tumors
☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐	Venereal Disease
						☐	☐	Whopping Cough
						☐	☐	Other _____

Is there anything else that you think we should know about your child? (Disabilities or Handicaps) _____

_____

I certify that I have read and understand the above questions. I will not hold Dr. Michael Worman, or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

Because your child is a minor, it is necessary that we have signed permission from a parent/guardian for any and/or all necessary dental services. Your signature below indicates permission granted.

COMMITMENT POLICY

COMMITMENT TO APPOINTMENT POLICY:

We reserve time for each patient in our practice. An appointment put in our schedule with your name in it is a bond of trust that we will be here to serve you and you will be present for that appointment Therefore, our office policy in this regard is extremely firm and inflexible. You must be present for all scheduled appointments. We do no allow cancellations or constant short-notice changes. We charge for all cancellations made less than 48 hours in advance. (We do not accept recorded messages as appointment cancellations or changes). Your signature indicates that we must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT:

We believe we have a responsibility to use our best professional care, skill and judgment in planning for your dental treatment. Payment is expected at the time services are rendered, unless other financial arrangements were made. We work with all insurance companies to secure benefits. Insurance companies have different benefits available to which you are entitled according to the plan you chose. Should the account become delinquent and turned over to a collection agency, you are responsible for the balance and all collection fees.

_____	_____	_____
Signature of Parent/Guardian	Relationship to patient	Date

COMMENTS _____

_____

_____

_____

_____

_____

Michael A. Worman, D.D.S., P.A.
Sandra A Worman, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ Other (Please Specify)

Worman and Worman Dentistry for Children
Michael A Worman, DDS, PA
Sandra A Worman, DDS

Ph: 727.321.6911
Fx: 727.328.2120

We reserve time for each patient in our practice. Please arrive promptly for all scheduled appointments. Lateness of more than 10 minutes will necessitate a rescheduling of the appointment. All cancellations and rescheduling of appointments requires 48 hours notice. Should you cancel an appointment with less than 48 hours notice, it will constitute a broken appointment and a $50.00 fee will be assessed per child. We adhere strictly to this policy.

All co-pays are due and payable at the time of service, so please be aware of your insurance benefits. Should the account become delinquent and turned over to a collection agency, you are responsible for the balance and all legal and collection fees.

We gladly accept cash, personal checks and all major credit cards for payment. In the event you have a check returned, the return fee is $35.00. The original check amount *plus* the $35.00 fee are then due in the form of a cash payment only. All further appointments will then be cash or credit card only.

Signature:_____

Date:_____