

Dear Parents,

We would like to welcome you and your family to our pediatric dental practice. We hope that this letter will answer some of your questions and familiarize you with our office procedures and philosophy.

BASIC TREATMENT PHILOSOPHY

We believe in the prevention of dental disease, malocclusion, fear and anxiety. We strive to make your child's experience in our office a positive one and encourage you to inform us of any specific concerns you may have. We understand the importance of good dental hygiene and oral care and are committed to providing your child the best care in a fun and caring environment.

FIRST VISIT

Our office, as well as the American Academy of Pediatric Dentistry, recommends that a child's first dental examination take place by his/her first birthday. This visit establishes a "dental home" for your child. At this visit we examine your child's teeth and soft tissue, teach you proper oral hygiene methods, perform a decay risk assessment and provide guidance with regard to diet and dental health. Thereafter, we would like to see your child once before the age of two and then every six months, when an oral examination, cleaning and topical fluoride application will be performed. Young children do best in the mornings when they are not overly tired.

You can help to make your child's first visit to the dentist enjoyable and a positive experience. The best thing you can do is to not over-prepare your child! Your child should be informed of the visit and told that the dentist and staff will explain all procedures and answer all of his or her questions. If we introduce your child to dentistry before any negative opinions are formed, we usually secure a better relationship and willing cooperation from your child.

Please refrain from saying, "The dentist will not hurt you" as this suggests that this is a very real possibility. Instead, it is better to say, "The dentist will be very gentle with you." Likewise, please refrain from using words such as "needle", "shot", "pull", "drill" or "hurt" as they might cause unnecessary fear. Our office makes a practice of using other words and phrases that are much more pleasant and non-threatening to the child.

Don't be upset if your child cries. Children are often afraid of anything new and different and this is their way of expressing themselves. We will do our best to work through these times with your child instead of work against them. Many times the children are really cooperating well, just loudly!

Parents are allowed back into the treatment area, but we ask that you assume the role of a passive observer so that Dr. Enright and Dr. Piedad can establish a rapport with your child. For the safety and privacy of all patients, we request that other children who are not being treated, unless very young, remain in the reception room with a supervising adult.

As a rule, no restorations will be performed at the first visit. If your child requires treatment beyond the first visit (or subsequent check-up appointments), we will review the recommended treatment involved, the number of visits required, the fees involved, and any concerns you may have. Our goal is to provide dental treatment in a non-threatening manner. We use a lot of the "Tell-Show-Do" method of introducing new procedures to children and most children do very well in this reassuring environment.

DENTAL X-RAYS

Dental x-rays are a vital and necessary part of your child's diagnostic process. Without them, certain dental conditions can and will be missed. If dental problems are found and treated early, dental care is more comfortable for your child and less expensive for you.

We understand that you may be concerned about your child receiving dental x-rays. The American Academy of Pediatric Dentistry has established guidelines concerning the use of dental x-rays in children which are designed to allow the dentist to adequately diagnose dental conditions while keeping exposure to a minimum. Generally radiographs are first taken between the ages of 2 – 6 and are only taken after the need for them is individually established.

Pediatric dentists are particularly careful to minimize the exposure of their patients to radiation. With modern techniques, the amount of radiation received is extremely small, and the risk is negligible. We feel the benefit of early detection and early treatment of dental problems far outweigh the risk from dental x-rays. Radiation is kept to a minimum by the use of modern digital equipment, shielding aprons and extremely sensitive film.

DENTAL SEALANTS

Besides routine dental care, the use of dental sealants is one of our best tools for preventing the formation of cavities. Sealants are a plastic coating applied to the chewing surfaces of the back teeth. We recommend them for all permanent molars and certain other permanent teeth and primary molars. Properly applied, sealants can help your child progress through the cavity prone years with a greatly decreased chance of decay.

ORTHODONTICS

We will evaluate your child's occlusion (bite) at the initial exam and each check-up thereafter. Please let us know if there is a significant family history of malocclusion as these traits can often be passed down through the generations. If it is apparent that orthodontic problems are evident, we will certainly discuss this with you, and if necessary, make the proper referrals.

OFFICE HOURS AND SCHEDULING

Office hours are Mondays through Thursdays from 7:30 AM to 4:30 PM and Fridays from 7:00 AM to 3:00 PM. We strive to see all of our patients promptly and trust that you will make every effort to be on time for your appointments. If, for any reason, you do arrive later than appointed, we will try to accommodate you, but please realize it may be necessary to reschedule. If your child cannot make his/her appointment, please notify us as soon as possible so that we may offer the appointment to another child. We realize that emergencies do arise which require the need to change appointments on short notice. However, failure to give 24 hour notice on business days will result in a broken appointment fee.

Children under the age of seven, and some special needs children, deal much better with the dental visit if they are seen earlier in the day rather than in the afternoon. Therefore, we schedule these children before 12:00 PM. Please realize that these children may have to miss some school to attend their appointments. We understand that preschool/school is important for this age group, but in the grand scheme of things, it is far more important that afternoon appointments be reserved for older children where missing school is of more consequence.

We require a parent or legal guardian to accompany the child on the first visit. We will ask you to complete an initial medical and dental history and consent form on your child. We will also ask you to complete a brief medical update form every six months, at which time you should inform us of any medical, dental, emotional or family changes. On subsequent visits, we ask you to inform us ahead of time if you cannot accompany your child and to inform us of any changes in health history, to update any other information which may have changed, and to discuss payment arrangements.

EMERGENCIES

Occasionally, we have to treat emergencies which may delay our seeing regularly scheduled patients. While we regret any inconvenience this may cause you, we are committed to giving emergencies priority treatment. If your child should have a dental emergency, call us as soon as possible. If immediate attention is required, we will make time available to see your child that day. In the event that we are not in the office, our voice mail gives instructions on how to contact the doctor on call for the practice.

PAYMENT

Payment is to be rendered at the time of services. We accept cash, checks, Visa and Mastercard. While we do not file insurance for you, we will provide you with an insurance statement which you can attach to a claim form for insurance reimbursement directly to you. If there are any questions, please call the office.

Thank you for placing your trust and confidence in us. Your understanding and cooperation is an important part of your child's dental care. We hope that this summary has answered many of your questions. If you have any other questions or would like to discuss anything with Dr. Enright or Dr. Piedad prior to your child's first visit, please do not hesitate to call us. We appreciate the opportunity to serve you and any friends or family you may refer to our office.

Sincerely,

Catharine A. Enright, DDS, MS and Stacy T. Piedad, DDS

A FEW NOTES ABOUT DR. ENRIGHT'S TRAINING AND BACKGROUND

Dr. Enright grew up in Evanston, IL and graduated from Emory University with a BA in Economics in 1977. She received her dental degree from Northwestern University Dental School in 1981, and completed her residency in Pediatric Dentistry at The Children's Memorial Hospital in Chicago while earning a master of science degree in Pediatric Dentistry from Northwestern University 1984. Dr. Enright returned to Atlanta in 1984 to assume the position of Assistant Professor in Pediatric Dentistry at Emory University School of Dentistry and was Program Director for the Pediatric Dental Residency Program from 1984 – 1986. She then became Director of Dentistry at Scottish Rite Children's Hospital and retained that position until the birth of her son in 1990 when she chose to go part-time. Dr. Enright continued on at Scottish Rite Children's Medical Center (now Children's Healthcare of Atlanta at Scottish Rite) and has extensive experience in treating children with medical, developmental and emotional problems. She opened her private practice of Pediatric Dentistry in 1996 and continues to hold staff privileges at Children's Healthcare of Atlanta and Pediatric Surgical Center of Atlanta Outpatient.

Dr. Enright is a Diplomate of the American Board of Pediatric Dentistry and is a fellow in the American Academy of Pediatric Dentistry. In addition, she serves on the Board of Trustees of Healthy Smiles, Healthy Children, The Foundation of the American Academy of Pediatric Dentistry. She also serves as a consultant/examiner on the American Board of Pediatric Dentistry and as a consultant to the Council on Continuing Education of the AAPD. Dr. Enright enjoys walking, weight training, traveling, skiing and baking in her spare time.

Dr. Enright is married to Dr. Walton Reeves, Jr., an internist with Laureate Medical Group. They have one son, Harrison, who is currently in high school at The Lovett School.

A FEW NOTES ABOUT DR. STACY PIEDAD'S TRAINING AND BACKGROUND

Dr. Stacy Tunney Piedad received her undergraduate degree in history from Duke University in 1998. She then attended Columbia University's School of Dental and Oral Surgery in New York City, where she earned her DDS degree in 2002. Dr. Piedad completed her residency in pediatric dentistry at Albert Einstein College of Medicine's Montefiore Medical Center in June of 2004. During her training, she had extensive experience with sedation techniques, general anesthesia, and trauma. She also developed expertise in the treatment of healthy infants, children and adolescents as well as those with medical and developmental issues. Upon completion of her program, Dr. Piedad worked in private practice in New York City from July 2004 to June 2005.

Dr. Piedad is a Diplomate of the American Board of Pediatric Dentistry and is a fellow in the American Academy of Pediatric Dentistry. She is also involved in the Georgia Academy of Pediatric Dentistry, the Southeastern Society of Pediatric Dentistry, and the Hinman Dental Society. Dr. Piedad enjoys exercising, traveling and spending time with her family.

Dr. Piedad is originally from Pensacola, FL and is married to Dr. Bryan Piedad, a cardiologist with Solaris Heart and Vascular Group. They are the proud parents of two daughters: Ashley, born in August, 2005 and Isabel, born in September, 2008, who attend Saint Anne's Day School.

Catharine A. Enright, DDS, MS, PC

Pediatric and Adolescent Dentistry

3280 Howell Mill Road N.W. Suite #230

Atlanta, GA 30327

(404) 351-PEDO (7336)

— FAMILY INFORMATION —

Date _____

Patient's Full Name _____ Preferred Name _____ DOB _____ Age _____ Sex _____

School _____ Grade _____

Residence Address _____

City _____ State _____ Zip _____ Home Phone # _____

Mother's Name _____ DOB _____ SS# _____ Phone (Cell) _____

Mother's Employer _____ Phone (W) _____

E-mail Address _____

Father's Name _____ DOB _____ SS# _____ Phone (H) _____

Father's Employer _____ Phone (W) _____

E-mail Address _____ Phone (Cell) _____

Marital Status of Parents Single Married Widowed Separated Divorced Partnered

With whom does the child reside? _____

Person financially responsible for child's account? _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone # _____

Other family members treated in our practice _____

Whom may we thank for referring you? _____ Phone # _____

Child's favorite sport, toy, activity, TV show, fictional character _____

—MEDICAL HISTORY—

Name of Pediatrician or Family Physician _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Does your child receive regular medical examinations? Y N Date of last exam _____

Is your child in good health? Y N

Is your child up-to-date on required vaccinations? Y N If no, please explain _____

Was pregnancy and delivery normal? Y N Is your child adopted? Y N

Is your child under medical care at the present time? Y N

If yes, please explain _____

Is your child presently taking any medications? Y N

If yes, please explain _____

Is your child allergic to any medications? Y N

If yes, please explain _____

Is your child allergic to any foods or environmental substances? Y N

If yes, please explain _____

Is your child allergic to latex? Y N

Is there a family history of missing teeth? Y N

Is there any significant family history? Y N

If yes, please explain _____

Has your child had any history of or difficulty with the following:

- | | | |
|--|---------------------------------------|--|
| ADD/ ADHD (Circle one) | Epilepsy | Pervasive Developmental Disorder (PPD) |
| Aids or HIV+ (Circle one) | Gastrointestinal Problems / Reflux | Pneumonia |
| Anemia | Handicaps / Disabilities | Rheumatic Fever |
| Autism | Headaches | Seizures |
| Behavior Problems | Heart Murmur* | Shunts* |
| Blood Disorders | Heart Disease* | Sickle Cell Disease |
| Bleeding Problems/Bruising Easily | Hemophilia | Sinus Problems |
| Brain Injury | Hepatitis | Skin Problems |
| Cancer* (Chemotherapy/Radiation) (circle) | Infections (Viral/Bacterial) (circle) | Sleep Disorders |
| Cerebral Palsy | Jaundice | Speech Disorders |
| Cleft Lip/Palate | Kidney or Bladder Problems | Thyroid |
| Congenital Birth Defects/Genetic Disorders | Learning Disorders | Tonsils/Adenoids |
| Diabetes | Liver | Transfusions |
| Ears or Hearing | Lung | Transplants |
| Eyes | Mental Retardation | Tuberculosis |
| Emotional Problems | | Other |

Please describe the items checked above:

* Have you ever been told that your child requires antibiotics prior to dental treatment? Yes No

If yes, please explain:

Has your child ever been hospitalized? Yes No Reason: _____

Has your child ever received general anesthesia? Yes No Any problems? Yes No

If yes, please explain: _____

In learning and development, do you consider your child Advanced Average Delayed

Please Note:

Payment is expected at the time of treatment. You may pay by cash, check, Visa, Mastercard or debit card. An insurance statement will be provided to you at the end of each appointment which you may file directly with your insurance company. We do not participate in any managed care or preferred provider programs.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I give my consent to needed dental services which may include topical fluoride application, necessary x-rays, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for my child.

Signature of Parent or Legal Guardian

Date

Medical and Dental History reviewed by:

Date