

Pediatric Dentistry

Dr. Cris Ann Ternisky

Dr. Golnaz Jalali

Dr. Jason Shannon

Date: _____

Dear _____,

Welcome to our dental practice. I would like to thank you for choosing us to provide your child/children with dental care and a future of good oral health.

Please fill out the enclosed health history and financial policy and give it to us at the time of your appointment. One of our staff members will be available to answer any questions or assist you at this time.

We have reserved _____ **am** / **pm** on _____, for your appointment. In order to process your paperwork efficiently, we would appreciate if you would arrive ten minutes before your appointment. Enclosed is information about our doctors and directions to our McLean office.

We look forward to meeting you.

Respectfully yours,

Shelley Ford

Shelley Ford

Office Manager

WHAT IS A PEDIATRIC DENTIST?

The pediatric dentist is a specialist who is dedicated to the oral health of children from infancy throughout the teenage years. The very young, pre-teens, and teenagers all need different approaches in dealing with their behavior, guiding their dental growth and development and helping them avoid future dental problems. The pediatric dentist is best qualified to meet these needs.

Pediatric dentists have had special training which allows them to provide the most up-to-date and thorough treatment for a wide variety of children's dental problems. A pediatric dentist completes a two year residency program in pediatric dentistry after graduating from dental school. They are trained and qualified to treat special patients who may have emotional, physical, or mental handicaps. Because of this specialized training and commitment to comprehensive oral health, many parents wisely choose a pediatric dentist to treat their children.

**Definition from the American Academy of Pediatric Dentistry*

The following are the hours of operation and guidelines for appointments

MONDAY	8:30 _{am} - 5:30 _{pm}
TUESDAY	8:30 _{am} - 4:30 _{pm}
WEDNESDAY	8:30 _{am} - 4:30 _{pm}
THURSDAY	8:30 _{am} - 2:30 _{pm} Summer, 1:00 _{pm} – 4:30 _{pm} School Year
FRIDAY	8:30 _{am} - 2:30 _{pm} Summer, 8:30 _{am} – 4:30 _{pm} School Year

Appointments are reserved specifically for your child. If a cancellation is unavoidable, please call the office at least 24 hours in advance in order to avoid the \$50.00 cancellation fee. Younger children (5 and under) and restorative procedures (fillings, extractions, etc.) are scheduled in the morning or early afternoon. Children are fresher and more prepared in the morning for these types of procedures.

INTRODUCING OUR SPECIALISTS:

DR. MIKE - Retired

Dr. Michael J. Ternisky attended Purdue University for his undergraduate studies and achieved his doctoral degree in dentistry from Indiana University in 1965. He furthered his training in adult dentistry while completing a rotation with the Air Force in Charleston, South Carolina. Dr. Mike completed pediatric residency at Eastman Dental Clinic in Rochester, New York. In 1969 he opened his practice in McLean, Virginia. He was an assistant professor of pediatric dentistry, at the school of dentistry at Georgetown University, for twenty years. Dr. Mike is an active member of the American Dental Association, the Academy of Pediatric Dentistry, the Northern Virginia Dental Society, and the Fairfax Dental Society. He is married to Mary Ternisky and the father of three grown children.

DR. CRIS ANN

Dr. Cris Ann Ternisky attended West Virginia University and received a degree in biological studies in 1987. In 1991 she graduated from the school of dentistry at the Medical College of Virginia in Richmond and later completed her residency in pediatric dentistry at the University of Maryland at Baltimore. Dr. Cris has worked throughout school training with Dr. Mike since the age of fifteen. Not a stranger to his staff, she joined her father's practice in 1993. Dr. Cris is an active member of the American Dental Association, the Academy of Pediatric Dentistry, the Northern Virginia Dental Society, and the Tyson's Dental Study Club. She is married to Dr. Mark Luposello, an orthodontist in McLean, Virginia. They are the proud parents of two children, Isabel and Mark Reid.

DR. JASON

Dr. Andrew "Jason" Shannon attended James Madison University receiving his Biology degree in 1999 and his doctoral degree from Tufts University School of Dental Medicine in 2005. In 2007, Dr. Jason completed his pediatric residency at St. Joseph's Hospital in Providence, Rhode Island. Dr. Jason is an active member of the American Dental Association and the Academy of Pediatric Dentistry. He is married Linda Shannon, a special education teacher at Cedar Lane School in Vienna, VA.

DR. GOLNAZ

Dr. Golnaz Jalali attended the University of Virginia where she received her degree in Chemistry with a specialization in Biology in 2007 and then obtained her doctoral degree from Virginia Commonwealth University School of Dentistry in 2011. Dr. Golnaz served as the chief resident and completed her pediatric residency in 2013 at Jacobi Medical Center in Bronx, New York. Dr. Golnaz is an active member of the American Dental Association and the American Academy of Pediatric Dentistry. She enjoys cooking, yoga and watching sports.

The availability of doctors depends on the day and time of your appointment. Our office will always *TRY* to accommodate any special requests if you prefer to see a particular doctor.

DIRECTIONS TO THE MCLEAN OFFICE

From the Beltway:

- take Route **123 north (exit 46B)**
- 5th light** (1.8 miles) turn **RIGHT** onto **Old Dominion Drive**
- at the **3rd light** (.6 mile) turn **RIGHT** on **Whittier Avenue**
- office address: 6711 Whittier Avenue, the 3rd building on the left
(McLean Doctors' Building)

From Reston:

- take the Dulles Toll Road (east- towards Washington D.C.)
- take Route **123 north** to McLean (exit 19B)
- 2nd light** (1.1 miles) turn **RIGHT** onto **Old Dominion Drive**
- at **3rd light** (.6 mile) turn **RIGHT** on **Whittier Avenue**
- office address: 6711 Whittier Avenue, the 3rd building on the left
(McLean Doctors' Building)

From the George Washinton Parkway

- take Route 123 south (Chain Bridge Road)
- go 3 miles and turn **LEFT** onto **Old Dominion Drive**
- at **3rd light** (.6 mile) turn **RIGHT** on **Whittier Avenue**
- office address: 6711 Whittier Avenue, the 3rd building on the left
(McLean Doctors' Building)

***We are on the 1st floor Suite #102*
6711 Whittier Avenue
703-356-1875**

The availability of doctors depends on the day and time of your appointment. Our office will always *TRY* to accommodate any special requests if you prefer to see a particular doctor.

Welcome To Our Practice

We are pleased to welcome you and your child to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

Date _____

Patients Name _____
Last First MI

Nickname _____ Birthdate ____ / ____ / ____ Sex M ____ F ____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Mother's Name _____ Father's Name _____

I UNDERSTAND THAT DR. TERNISKY'S OFFICE WILL BE CONTACTING BY PHONE, TEXT OR EMAIL TO CONFIRM ALL APPOINTMENTS THAT I SCHEDULE WITH THE OFFICE. I AUTHORIZE DR. TERNISKY'S OFFICE TO CONTACT ME AT THE FOLLOWING NUMBERS:

Home Phone _____

Mom's Cell _____ Dad's Cell _____

Mom's Work _____ Dad's Work _____

Email _____

We prefer to reach you directly, otherwise we will leave a message and ask that you call back to confirm. If a cancellation is unavoidable, please call the office 24 hours in advance to avoid the \$50.00 cancellation fee.

In case of an emergency whom should we contact (name, relationship, and number)?

Whom may we thank for referring you? _____

Pediatrician/General Physician _____
Name Office Phone Number

Under the care of any other physicians? Yes No If yes, for what? _____

MEDICAL HISTORY:

Please list any medications the minor/child is taking:

Please list any allergies your child may have (latex, food or dye, medication, etc):

****ALLERGIC TO:**



Has your child had any history of or difficulty with any of the following? If yes please (√).

___ A.I.D.S./H.I.V.	___ Cerebral Palsy	___ Heart Problems	___ Sensory Issues
___ ADD/ADHD	___ Developmentally Delayed	___ Hepatitis	___ Sinus Issues
___ Anemia	___ Diabetes	___ Kidney Disease	___ Thyroid Issues
___ Asthma	___ Epilepsy	___ Liver Disease	___ Tuberculosis
___ Autism	___ Fainting	___ Mononucleosis	___ Other
___ Cancer	___ Hearing Problems	___ Seizures	_____

I will inform the office of any future medical changes concerning my child.

FINANCIAL AND INSURANCE INFORMATION:

If you have an insurance company that we do not submit for, you will be required to pay in full at the time of service (cash, check, Visa, Mastercard, or Discover). We will provide you with an insurance claim that you may submit for your reimbursement.

WE PARTICIPATE WITH: AETNA, DELTA DENTAL PREMIER, CONCORDIA, CIGNA (Total DPPO or DPPO), UNITED HEALTHCARE DENTAL, DENTAQUEST CHOICE) OR VA SMILES FOR CHILDREN (MEDICAID). PLEASE FILL OUT THE FOLLOWING INFORMATION SO THAT WE MAY SUBMIT FOR YOU.

Policy Holder's Name _____ Birthdate ____ / ____ / ____

Employer _____ Plan Name _____

Soc Sec # _____ Group # _____ Policy # _____

Insurance Mailing Address _____

Secondary Dental Insurance No Yes If Yes, Plan Name _____

I authorize the dentist to release all information needed to secure the payment of benefits and I authorize the use of my signature on all my insurance submissions, whether manual or electronic.

I understand that I am financially responsible for all charges whether or not paid by insurance.

If it is necessary for your child/children to have extensive dental treatment, a monthly payment plan can be arranged with the office. A credit card must be placed on file in order to pay in monthly installments. Any balance remaining unpaid for 90 days, will receive a final notice letter before being sent to collections. In the event that my account is sent to collections, I will be responsible for any and all costs incurred in the collection of this debt. This includes: interest rates of 21% of the unpaid balance from the last date of service, attorney fees at the rate of 33% and court costs.

CONSENT AND AUTHORIZATION

I am the parent, guardian, or personal representative for the above patient and there are no court orders in effect that would prevent me from signing this consent. I hereby request and authorize the doctors of this practice and the dental staff to perform necessary dental services, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

To the best of my knowledge, the above information is complete and correct. I have read and understand this document in its entirety outlining office policies, patient and family responsibilities, and agree to abide by all terms stated herein.

Date _____

Signature _____ Print Name _____

Social Security # _____ OR Driver's License # _____