INSTRUCTIONS

Welcome to our office! Thank you for choosing CHILDREN’S DENTISTRY to provide your child’s dental care. We make it our goal to exceed your expectations and we know that you will experience outstanding treatment in a caring, comfortable, and fun atmosphere.

ENROLLMENT FORMS
To facilitate the ease of your first visit with us, please fill them out as completely as possible. Be sure to sign the Registration and Medical History forms. Please bring all completed paperwork (originals only, no faxes please) to our office for your appointment so that the information can be entered into your child’s chart. Should you have any questions or concerns, feel free to call so that we may assist you.

TRANSFER OF RECORDS
If you are transferring from another office, we include a form to have your records forwarded to us. Please fax or mail this transfer form to your prior dentist as soon as you can; we will be able to provide a comprehensive exam if we have the records before your visit. At CHILDREN’S DENTISTRY, we have a conservative radiographic policy and we may not require x-rays depending upon the age and quality of those from your prior dentist.

PREMEDICATION
Some children need to take premedication with antibiotics prior to a dental visit. If your child has a heart abnormality, or another condition which may necessitate premedication, we require a letter from a pediatrician or cardiologist; the letter must state whether or not premedication is necessary. This information can be faxed to (603) 527-2501 (Gilford), (603) 536-2506 (Plymouth), (603)444-2506 (Littleton), or emailed to info@childrensdentistnh.com.

Welcome to our practice and we look forward to a long relationship with your family!
**CHILD’S REGISTRATION**

<table>
<thead>
<tr>
<th>Patient Name: __________________________________________</th>
<th>Birth Date: <strong><strong><strong>/</strong></strong><em>/</em></strong>____</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td>Patient lives with: □ Both Parents □ Mother □ Father □ Other: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Father/</td>
<td>Mother/</td>
</tr>
<tr>
<td>Guardian:</td>
<td>Guardian:</td>
</tr>
<tr>
<td>Street Address: ________________________________________</td>
<td>Street Address: ____________________</td>
</tr>
<tr>
<td>Home Phone:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td></td>
</tr>
<tr>
<td>Mobile Phone:</td>
<td></td>
</tr>
<tr>
<td>Employer:</td>
<td></td>
</tr>
<tr>
<td>Employer Address: _________________________________</td>
<td>Employer Address: ________________________________</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

**DENTAL INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>Primary Dental Insurance</th>
<th>Secondary Dental Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Name:</td>
<td>Subscriber Name:</td>
</tr>
<tr>
<td>Insurance Co. Name:</td>
<td>Insurance Co. Name:</td>
</tr>
<tr>
<td>Group Plan/Employer’s Name:</td>
<td>Group Plan/Employer’s Name:</td>
</tr>
<tr>
<td>Insurance Co. Address:</td>
<td>Insurance Co. Address:</td>
</tr>
<tr>
<td>Insurance Co. Phone #:</td>
<td>Insurance Co. Phone #:</td>
</tr>
<tr>
<td>Group #:</td>
<td>Group #:</td>
</tr>
<tr>
<td>Insured ID #:</td>
<td>Insured ID #:</td>
</tr>
</tbody>
</table>

As a courtesy, and to ease the billing process for you, we accept assignment of benefits from your insurance carrier. As we deal with insurance on your behalf, carriers require that we keep your signature on file.

Please sign both statements below.

I reviewed the treatment plan(s) and I authorize the release of any information relating to the claim(s).

______________________________________________
Signature of parent / guardian

I hereby authorize direct payment to the above named dentists of the group insurance benefits otherwise payable to me.

______________________________________________
Signature of insured parent / guardian

For those patients without insurance coverage, payment in full is required at the time of the treatment. For patients with insurance, the copay and/or deductible is due at the time of treatment. The parent who accompanies the child to our office is responsible for payment at the time of service unless arrangements have been made prior to the visit. All office correspondence will be addressed to the child’s place of residence. It is important that you keep our office aware of changes in your address, phone numbers, and insurance status.

**By signing below you have read and understand our office’s policies.**

Signature of parent / guardian __________________________ Relationship to patient __________________________ Date __________________________

[www.childrensdentistnh.com](http://www.childrensdentistnh.com)
CHILD’S HEALTH HISTORY

Child’s Name: _________________________________________________________ Birth Date: ___/___/_______

First    Middle    Last
Nickname: _______________________   □ Male □ Female    Favorite Interests: _______________________________

Present dental problem (if any) as you see it: ____________________________________________________________________

Is this your child’s first visit to the dentist? □ Yes □ No

Name of prior dentist: _______________________ Date of visit: ___/___/_____ Purpose of last visit:________________________

Has your child had unpleasant dental experiences? □ Yes □ No Explain: ______________________________________________

Have any other children in your family been to our office? □ Yes □ No

Names and ages of other children: ____________________________________________________________________________

Whom may we thank for referring you to our office? _______________________________________________________________

MEDICAL HISTORY

Pediatrician: ____________________________________________________ Date of last physical: _____/_____/______

Phone: (_____)______-_______ Address: _______________________________________________________________

Is your child in good health? □ Yes □ No  Are your child’s immunizations current? □ Yes □ No

Is your child taking any medications? □ Yes □ No

List medications: __________________________________________________________________________________________

Has your child been hospitalized or had surgery? □ Yes □ No

If yes, explain: ____________________________________________________________________________________________

Does your child have allergies to the following? □ LATEX □ Food / Dyes □ Pollen / Dust □ Other:___________________________

Does your child have reactions or allergies to any medications? □ Yes □ No

Explain: _________________________________________________________________________________________________

PLEASE CHECK YES OR NO REGARDING YOUR CHILD’S HISTORY OF ANY OF THE FOLLOWING:

YES  NO      YES  NO               YES  NO
□  □ Allergies to Medications  □  □ Chronic Ear Infections  □  □ Hyperactivity [AD(H)D]
□  □ Anemia          □  □ Cleft Lip / Palate               □  □ Kidney Disease
□  □ Asthma          □  □ Convulsions / Seizures          □  □ Leukemia
□  □ Autism/Sensory Disorder □  □ Diabetes               □  □ Mental Handicap
□  □ Birth Defects  □  □ Epilepsy                        □  □ Nutritional Deficiency
□  □ Bladder Problems  □  □ Emotional Disability   □  □ Premature Birth
□  □ Bleeding Disorder/Brusing Easily  □  □ Eye Problems  □  □ Rheumatic Fever
□  □ Blood Transfusions □  □ Fainting or Dizziness  □  □ Scoliosis
□  □ Bone/Joint (Orthopedic) Problems □  □ Gastrointestinal Disorders □  □ Sensory
□  □ Brain Injury □  □ Growth / Development Problems □  □ Sickle Cell Disease or Trait
□  □ Cancer or Malignancies □  □ Hearing / Speech Problems □  □ Spina Bifida
□  □ Cerebral Palsy □  □ Heart Disease / Malformation □  □ Syndrome: __________________
□  □ Child Abuse (physical or sexual) □  □ Heart Murmur □  □ Tuberculosis
□  □ Chronic Adenoid / Tonsil Infection □  □ Hepatitis / Liver Disease □  □ Other: _____________________
□  □ Chronic Headaches □  □ HIV Infection

If you answered YES to any of the above, please explain: __________________________________________________________

Please make us aware of current medical issues including medications, pending surgery, recent injuries, or any other
information we should know about your child: ____________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

My signature below (as the parent or guardian) authorizes the completion of all agreed upon dental services for my child.
In addition, I certify that the above information is complete and accurate, to the best of my knowledge.

______________________________ _____________________________ ______/______/_______
(Signature of parent / guardian)     (Relationship)    (Date)

____ YES, Children’s Dentistry may use my child’s photo on their website & social media platforms
____ NO, Children’s Dentistry may NOT use my child’s photo on their website & social media platforms
NEW APPOINTMENT CONFIRMATION POLICY

In order to accommodate and better serve all of our patients we will be installing a new procedure for appointment confirmations. You will receive an automated appointment reminder message 7 days prior to your scheduled appointment. Please verify your appointment time via text, email or phone at least 5 days prior to your appointment. If our office has not received a confirmation from you 48 hours prior to your appointment you will be removed from our schedule.

We thank you for your understanding and cooperation with this new policy!
INSURANCE INFORMATION

In order to accommodate you with the appropriate dental services we ask that you provide us with necessary information so that we can assure the accuracy of your dental insurance and policy. Also so that you are informed of your dental plan, what it provides you and if you have out of network coverage, any waiting periods, maximum benefits, deductibles or restrictions.

When you do contact us, we will need the following information:

Policy Holders Full Name

Policy Holders D.O.B.

Policy #

Policy Social Security #

Insurance Company Name

Address City State Zip

Phone #’s

**Out of Network**- the insurance may choose what practice you have to go in order for them to cover services or they may have different fees that they will pay for the services

**In Network**- you get to choose what practice to go to for your dental services

If new insurance you may have a **waiting period** to have certain services done

**Maximum benefits** is a dollar amount that the insurance will pay per year, per person

You have to pay your **deductible** prior to insurance paying out on your benefits. (Usually at your first restorative visit)

Your plan may have **restrictions** on certain dental procedures (may not pay for white filling)