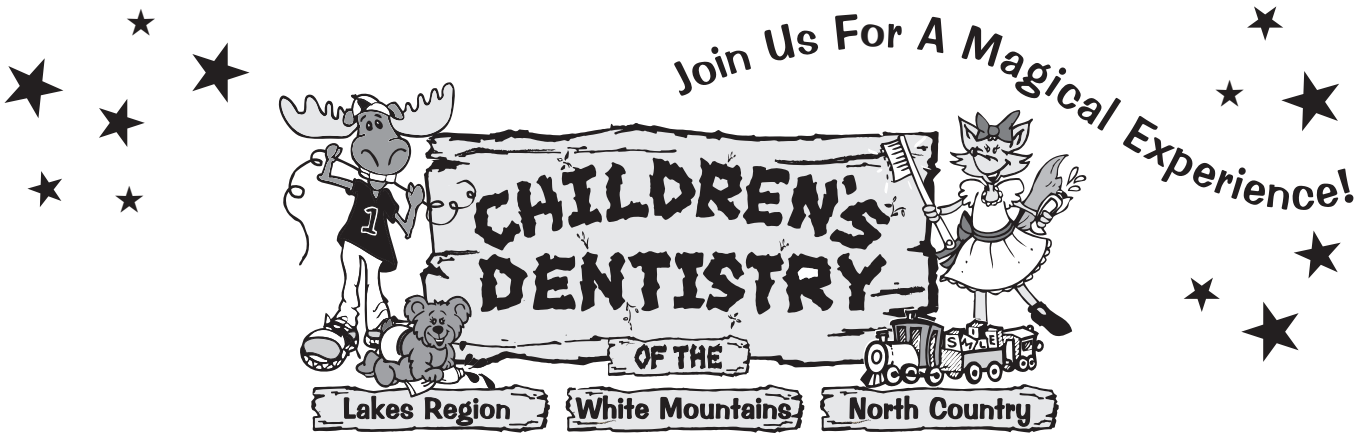


INSTRUCTIONS

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!

My Dentist ROCKS!

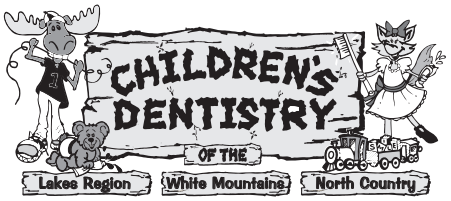
Three great locations!

GILFORD
Lakes Professional Center
369 Hounsell Avenue • Suite #1
Gilford, NH 03249
603-527-2500 • Fax 603-527-2501

PLYMOUTH
Boulder Point
94 Boulder Point • Suite #1
Plymouth, NH 03264
603-536-2500 • Fax 603-536-2506

LITTLETON
81 Bethlehem Rd. • Suite #1
Littleton, NH 03561
603-444-1500 • Fax 603-444-2506

www.childrensdentistnh.com



Dr. Melissa Kennell
Dr. Matthew Smith
Dr. Timothy Smith

Gilford: 603-527-2500 • Plymouth: 603-536-2500 • Littleton: 603-444-1500

CHILD'S REGISTRATION

Patient Name: _____ Birth Date: _____/_____/_____
First Middle Last

Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Father/ Guardian: _____	Mother/ Guardian: _____
First Middle Last	First Middle Last
Street Address: _____	Street Address: _____
Town: _____ Zip: _____	Town: _____ Zip: _____
Social Security #: _____ D.O.B.: _____	Social Security #: _____ D.O.B.: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Mobile Phone: _____	Mobile Phone: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
_____	_____
Email: _____	Email: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Subscriber Name: _____	Subscriber Name: _____
Insurance Co. Name: _____	Insurance Co. Name: _____
Group Plan/Employer's Name: _____	Group Plan/Employer's Name:, _____
Insurance Co. Address: _____	Insurance Co. Address: _____
_____	_____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____
Group #: _____	Group #: _____
Insured ID #: _____	Insured ID #: _____

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

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	☐	☐	Emotional Disability	☐	☐	Nutritional Deficiency
☐	☐	Bladder Problems	☐	☐	Epilepsy	☐	☐	Premature Birth
☐	☐	Bleeding Disorder/Bruising Easily	☐	☐	Eye Problems	☐	☐	Rheumatic Fever
☐	☐	Blood Transfusions	☐	☐	Fainting or Dizzinesss	☐	☐	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