Welcome To Our Office
Alan F. Kennell, DDS, MS, PC

TELL US ABOUT YOUR CHILD DATE:______________

Prefers to be called ____

____
First Name Middle init. Last Name

____
Street Address City/Zip

____
Mailing address if different City/Zip

____
Home Phone Work Phone/ext. Cell Phone

____
Primary Email

With whom does child reside?______________________________

Who will be scheduling appointments?______________________

Home #: ______________Work #: ______________ Ext.______

Age: _________Birth Date: _____/_____/_______ Gender: __M __F

School your child attends: ______________________________

Interests/Hobbies: ______________________________________

Any Allergies to: __ Seafoods __ Metal __ Latex

Other Allergies: ____
(Please Specify)

Is your child under doctor's care? __ YES __ NO If yes, please explain: ____

Please list any medications your child is taking:

____

Does your child require antibiotic pre-medication prior to dental procedures? __ Yes __ No

PLEASE CHECK any history your child may have had:

__ Anemia	__ Abnormal Bleeding	__ Emotional Problems
__ Epilepsy	__ Convulsions	__ Excessive Bleeding
__ Cancer	__ Rheumatic Fever	__ Speech Impediment
__ Asthma	__ Tuberculosis	__ Mental Disturbance
__ Hepatitis	__ Diabetes	__ Heart Trouble/Murmur
__ HIV+	__ Liver Disease	__ Hearing Problems

Please list any illness or problems not listed above:

____

____

MOTHER'S INFORMATION ___ Stepmother ___ Guardian

Name: ____

____
Street Address City/Zip

____
Mailing Address if different City/Zip

Phone: ____
(home) (work)

Employer: ____

Occupation: ____

FATHER'S INFORMATION ___ Stepfather ___ Guardian

Name: ____

____
Street Address City/Zip

____
Mailing Address if different City/Zip

Phone: ____
(home) (work)

Employer: ____

Occupation: ____

PERSON(S) RESPONSIBLE FOR ACCOUNT

Name: ____

Relationship: ____

____
Street Address City/Zip

____
Mailing Address if different City/Zip

Phone: ____
(home) (work)

Employer: ____

Occupation: ____

What most concerns you regarding your child's teeth? ____

Who is your child's dentist? ______________________________ Did he/she refer you to our office? ___ YES ___ NO

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

Other family members treated at our office? ____

Is your child covered by Orthodontic Insurance? ___YES ___NO Name of Insurance Company ____________________

Please Fill out the Dental/Orthodontic insurance information on the back of this form. We will gladly submit for insurance benefits on your behalf however, if the insurance company does not pay their portion for any reason, it becomes your obligation.

Alan F. Kennell, DDS, MS, PC
783 North Main Street
Laconia, NH 03246
524-7404

CONSENT FOR ORTHODONTIC SERVICES

I voluntarily consent to orthodontic services for ______________________________, including diagnostic
(patient name)
procedures, provided by Alan F. Kennell, DDS, MS, PC.

Signature: ____ Date: ______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date: ______________________

APPOINTMENT REMINDERS

I would like to receive appointment reminders by **email** and/or **text.**

____ I would like to receive **email** appointment reminders.
Email address: ____
____ I would like to receive **text** appointment reminders.

DENTAL/ORTHODONTIC INSURANCE INFORMATION

Subscriber Name: ______________________________________ Subscriber DOB: ________________________

Place of Work: ____

Name of Insurance Company: ____________________________ Insurance Phone #: ______________________

Subscriber Identification Number: ____

Group Number: ____

I authorize release of any information relating to claims for the patient listed above. I agree to be responsible for payment for services rendered during any ineligible period and/or not covered by my dental/orthodontic benefits.

____ ______________________________
Signed (Patient, or parent if minor) (Date)