

WELCOME

— TO OUR ORTHODONTIC OFFICE —

Alan F. Kennell, DDS, MS, PC

Date: _____

TELL US ABOUT YOUR CHILD

Prefers to be called _____

_____ (first name) (middle init.) (last name)

_____ (street address) (city & zip)

_____ (mailing address if different) (city & zip)

With whom does child reside?

Who will be scheduling appointments?

Hm# _____ Wk# _____ Ext. _____

Child's Age _____ Date of Birth _____ 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:

Please circle 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 Problem

What most concerns you regarding your child's teeth?

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 _____

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 _____

Name of Employee holding coverage _____ Subscriber ID# _____

We do not accept direct insurance benefits with the exception of **Northeast Delta Dental. We will, however, gladly submit for benefits on your behalf once we receive a completed **dental** claim form from you or the parent/guardian holding the insurance coverage.*

Alan F. Kennell, DDS, MS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Signature}

{Date}

CONSENT FOR ORTHODONTIC SERVICES

I voluntarily consent to orthodontic services for _____, including diagnostic procedures, provided by Alan F. Kennell, DDS, MS, PC.

Signature _____ Date _____