Welcome To Our Office

Alan F. Kennell, DDS, MS, PC

TELL US ABOUT YOURSELF

DATE:______________

I prefer to be called ______________________________________

____
First Name　　Middle init.　　Last Name

____
Street Address　　City/Zip

____
Mailing address if different　　City/Zip

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

__Single __Married __Divorced __Widowed __Separated

Any Allergies to: __ Seafoods　__ Metal　__ Latex

Other Allergies: ______________________________________
(Please Specify)

Are you under a doctor's care? __ YES __ NO　If yes, please explain: ______________________________________

Name of Doctor: ______________________________________

Please list any medications you are taking:

____

Do you require antibiotic pre-medication prior to dental procedures?

__ Yes __ No

PLEASE CHECK any history you 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:

____

____

EMPLOYMENT INFORMATION

Occupation: ______________________________________

Employer: ______________________________________

____
Street Address　　City/Zip

____
Mailing Address if different　　City/Zip

Work Phone: ______________________________________

Best time to reach you: ______________________________

SPOUSE INFORMATION

Name: ______________________________________

____
Street Address　　City/Zip

____
Mailing Address if different　　City/Zip

Phone: ______________________________________
(home)　　(work)

Employer: ______________________________________

Occupation: ______________________________________

PERSON(S) RESPONSIBLE FOR ACCOUNT

(if other than you or your spouse)

Name: ______________________________________

Relationship: ______________________________________

____
Street Address　　City/Zip

____
Mailing Address if different　　City/Zip

Phone: ______________________________________
(home)　　(work)

Employer: ______________________________________

Occupation: ______________________________________

What most concerns you regarding your teeth? ______________________________________

Who is your 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? ______________________________________

Are you 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.
Cell # and carrier (ex. Verizon, US Cellular, etc.) ____

DENTAL/ORTHODONTIC INSURANCE INFORMATION

Subscriber Name: ____ Subscriber DOB: _________________________

Place of Work: ____

Name of Insurance Company: ____

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)