KENNELL ORTHODONTICS

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

_____
Home Phone Work Phone/ext. Cell Phone

_____
Primary Email

Age: _____Birth Date: _____/_____/_____ Gender: _____

☐ 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.

KENNELL
ORTHODONTICS

Alan F. Kennell, DDS, MS, PC
783 North Main St. 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: _____

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)

PHOTO RELEASE

I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, or other photographic, reproductions captured with still, motion picture, video, digital or other cameras for use by **Alan F. Kennell, DDS, MS, PC.**

_____ _____ _____
Patient Name Signature (patient, or parent if minor) Date