Children's Dental Center
of New Hampshire

James C. McAveeney, D.M.D.
Andrew T. Cheifetz D.M.D., M.Ed.
7 Route 101A, Amherst, NH 03031
(603) 673 – 1000 (v)
(603) 673-2422 (f)
hello@childrensdentalnh.com

Instructions for Downloadable Forms

Welcome to our office! Thank you for choosing Children's Dental Center of New Hampshire 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, we offer downloadable forms; please fill them out as completely as possible. Be sure to sign: 1) the HIPAA form, 2) the registration form, and 3) the two-page medical/dental history. We need all completed paperwork sent to our office ***before*** your child's visit.

You can email the forms to hello@childrensdentalnh.com, mail them to our address, or fax them to 603-673-2422. 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 email, 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 child's visit. At Children's Dental Center of New Hampshire 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 condition which may necessitate premedication, we require a letter from your child's physician. The letter must state *whether or not* premedication is required. This information can be emailed to hello@childrensdentalnh.com, faxed to 603-673-2422, or mailed.

Welcome to our practice and we look forward to a long relationship with your family!

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CHILD'S REGISTRATION

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

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

Father's Name: _____
First Middle Last

Street Address: _____
Town: _____ Zip: _____
D.O.B.:_____ Social Security #: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Employer: _____
Employer Address: _____
_____
Email: _____

Mother's Name: _____
First Middle Last

Street Address: _____
Town: _____ Zip: _____
D.O.B.:_____ Social Security #: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Employer: _____
Employer Address: _____
_____
Email: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

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

SECONDARY DENTAL INSURANCE

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

As a courtesy to our patients and to ease the billing process for you, we accept assignment of benefits from your insurance carrier. As we deal with your 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).
I hereby authorize direct payment to the above named dentists of the group insurance benefits otherwise payable to me.

X _____
Signature of insured parent / guardian

For patients with insurance, the co pay and/or deductible is due at the time of treatment. For those patients without insurance coverage, payment in full is required at the time of the 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 our brochure and understand our office policies.

X _____ _____ _____
Signature of parent / guardian | Relationship to patient | Date

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CHILD'S HEALTH HISTORY

Reviewed: _____ Date: _____

Child's Name: _____ Age: _____ Birth Date: ____/____/_____
First Middle Last

Gender: ☐ Male ☐ Female Nickname: _____ 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 last visit: ____/____/_____ Purpose of visit: _____
  Has your child ever had dental x-rays? ☐ Yes ☐ No If yes, Date: ____/____/_____
- Has your child had unpleasant dental experiences? ☐ Yes ☐ No Explain: _____
- 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	☐	☐	Cleft Lip / Palate	☐	☐	HIV Infection
☐	☐	Asthma	☐	☐	Convulsions / Seizures	☐	☐	Hyperactivity [AD(H)D]
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Mental Handicap
☐	☐	Birth Defects	☐	☐	Emotional Disability	☐	☐	Nutritional Deficiency
☐	☐	Bone/Joint (Orthopedic) Problems	☐	☐	Fainting or Dizziness	☐	☐	Premature Birth
☐	☐	Brain Injury	☐	☐	Gastrointestinal Disorders	☐	☐	Sickle Cell Disease or Trait
☐	☐	Bruising Easily/Excessive Bleeding	☐	☐	Growth / Development Problems	☐	☐	Spina Bifida
☐	☐	Cancer or Malignancies	☐	☐	Hearing / Speech Problems	☐	☐	Syndrome: _____
☐	☐	Cerebral Palsy	☐	☐	Heart Disease / Malformation	☐	☐	Other: _____
☐	☐	Child Abuse (physical or sexual)	☐	☐	Heart Murmur			_____

- 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: _____

_____

_____

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DENTAL HEALTH HISTORY

●How do you expect your child to react to the visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know
Explain: _____

●When does your child brush (check all that apply)? ☐ A.M. ☐ P.M. ☐ After snacking / eating
- Does an adult assist with brushing? ☐ Yes ☐ No When? _____
- Do you or your child use dental floss in cleaning his/her teeth? ☐ Yes ☐ No

●Does your child receive fluoride in any of the following forms?
- Fluoride vitamins: ☐ Yes ☐ No
- Water supply (either well or town water): ☐ Yes ☐ No ☐ Don't Know
- Toothpaste: ☐ Yes ☐ No

●Please let us know if your child has any oral habits: ☐ Bottle or sippy cup usage ☐ Thumb / Finger sucking ☐ Pacifier ☐ Mouth breathing ☐ Teeth Grinding ☐ Lip sucking

● Your child was nursed until age: _____ ● Your child was bottle fed until age: _____

●Has your child had any injuries to the teeth, mouth, or jaws? ☐ Yes ☐ No
Explain (age, teeth involved, nature of accident, treatment rendered): _____
_____

●How may we make this visit a positive experience for 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)

Thank you for filling out this form completely; your cooperation will enable us to help your child more effectively.
Our office commits to meeting and exceeding the standards mandated by OSHA, HIPAA, the CDC, and the ADA.

We appreciate your confidence in choosing our office and we look forward to an ongoing relationship!

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Financial Provisions

We at Children's Dental Center of New Hampshire are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available. In addition, we are dedicated to making top-quality care as cost-effective as possible.

So that you understand what amount you must pay at the visit, we provide a treatment plan for any work your child may need. This plan clearly illustrates your expected portion for each visit. ***Payment is required at the time treatment is rendered****.*

To assist you with your child's healthcare investment we provide several payment options:

1. **Cash** – includes personal checks and money orders
2. **Credit Card** – American Express, Visa, MasterCard, Discover
3. **Paypal** – You can pay your balance online using the security of PayPal.
4. **Financing** – As another alternative we offer an option for you to make your payments over time. We have two great companies:
   a. *Citi Health Card*: www.healthcard.citicards.com
      Citi offers the lowest rates available including some with no interest.
   b. *CareCredit*: www.carecredit.com
      CareCredit is backed by GE and offers low monthly payment options.

Dental Insurance

As you may realize, dental insurance benefits are often difficult to understand. We do not have a contract with your insurance company, only you do. We are not responsible for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment and we cannot guarantee what your insurance will do with each claim.

Our staff is happy to assist you with your insurance questions, so please ask.

We appreciate the confidence you place in our office for your family's dental care and we look forward to seeing you at your visit!

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Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign This Acknowledgement)

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

Printed name of Parent/Guardian

Please print the names of each child:

_____ _____

_____ _____

_____ _____

_____ _____

Signature Parent/guardian Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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Request for Transfer of Records

Child's Name	Date of Birth

Please transfer records *and* radiographs for the above listed children to:

Children's Dental Center of New Hampshire
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7 Route 101A
Colonial Park, Suite D
Amherst, NH 03031
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hello@childrensdentalnh.com

Thank you in advance for your cooperation in this matter!

Signature of parent / guardian	Relationship to patient	Date

A Mission For Quality. A Passion For Smiles!
www.childrensdentalnh.com