

# **Amherst Pediatric Dental Associates**

**James C. McAweeney, D.M.D.**  
Specialist in Pediatric Dentistry

**Andrew T. Cheifetz, D.M.D., M.Ed.**  
Specialist in Pediatric Dentistry

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7 Route 101-A, Suite D  
Amherst, NH 03031

Office: 603-673-1000  
Fax: 603-673-2422

## Instructions

Welcome to our office! Thank you for choosing Amherst Pediatric Dental Associates 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 (originals only, no faxes please) sent to our office **before** your appointment so that the information can be entered into your child's chart. Please mail the forms to our above listed address. 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 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 visit. At Amherst Pediatric Dental Associates 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 heart abnormality, heart murmur, or another condition which may necessitate premedication, we require a letter from a pediatrician or cardiologist; the letter must state *whether or not* premedication is necessary. This information can be faxed, (603) 673 – 2422, or emailed, info@PediatricDentistNH.com.

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

**[www.PediatricDentistNH.com](http://www.PediatricDentistNH.com)**



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CHILD'S HEALTH HISTORY

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

- Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
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 visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Purpose of last visit: \_\_\_\_\_
Has your child ever had dental x-rays? [ ] Yes [ ] No If yes, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
• Has your child had unpleasant dental experiences? [ ] Yes [ ] No Explain: \_\_\_\_\_
• Have any other children in your family been to our office? [ ] Yes [ ] No
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 [ ] [ ] Chronic Ear Infections [ ] [ ] HIV Infection
[ ] [ ] Anemia [ ] [ ] Cleft Lip / Palate [ ] [ ] Hyperactivity [AD(H)D]
[ ] [ ] Asthma [ ] [ ] Convulsions / Seizures [ ] [ ] Kidney Disease
[ ] [ ] Autism [ ] [ ] Diabetes [ ] [ ] Leukemia
[ ] [ ] Bladder Problems [ ] [ ] Emotional Disability [ ] [ ] Mental Handicap
[ ] [ ] Blood Transfusions [ ] [ ] Epilepsy [ ] [ ] Nutritional Deficiency
[ ] [ ] Birth Defects [ ] [ ] Eye Problems [ ] [ ] Premature Birth
[ ] [ ] Bone/Joint (Orthopedic) Problems [ ] [ ] Excessive Bleeding / Hemophilia [ ] [ ] Rheumatic Fever
[ ] [ ] Brain Injury [ ] [ ] Fainting or Dizziness [ ] [ ] Scoliosis
[ ] [ ] Bruising Easily [ ] [ ] Gastrointestinal Disorders [ ] [ ] Sickle Cell Disease or Trait
[ ] [ ] Cancer or Malignancies [ ] [ ] Growth / Development Problems [ ] [ ] Spina Bifida
[ ] [ ] Cerebral Palsy [ ] [ ] Hearing / Speech Problems [ ] [ ] Syndrome: \_\_\_\_\_
[ ] [ ] Child Abuse (physical or sexual) [ ] [ ] Hepatitis / Liver Disease [ ] [ ] Tuberculosis
[ ] [ ] Chronic Adenoid / Tonsil Infection [ ] [ ] Heart Disease / Malformation [ ] [ ] Other: \_\_\_\_\_
[ ] [ ] Chronic Headaches [ ] [ ] 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: \_\_\_\_\_



# Amherst Pediatric Dental Associates

## 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.  
Parent / Guardian Name

Please print the name of each child:

_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Signature of parent / guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

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### For Office Use Only

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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):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Request for Transfer of Records

_____ Child's Name	_____ Date of Birth
_____ Child's Name	_____ Date of Birth
_____ Child's Name	_____ Date of Birth
_____ Child's Name	_____ Date of Birth
_____ Child's Name	_____ Date of Birth
_____ Child's Name	_____ Date of Birth

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

Amherst Pediatric Dental Associates  
James C. McAveeny, D.M.D.  
Andrew T. Cheifetz, D.M.D., M.Ed.  
7 Route 101A  
Colonial Park, Suite D  
Amherst, NH 03031

(603) 673-1000  
info@PediatricDentistNH.com

Thank you in advance for your cooperation in this matter!

\_\_\_\_\_  
Signature of parent / guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

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## **Financial Provisions**

We at Amherst Pediatric Dental Associates 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.

*Since payment is required at the time treatment is rendered, please take a moment to review your child's treatment plan handout; it clearly illustrates what your expected portion is for each visit.*

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

1. Cash – includes personal checks and money orders
2. Credit Card – American Express, Visa, MasterCard, Discover, and PayPal  
You may now pay your balance online using the security of PayPal. Just visit our website ([www.PediatricDentistNH.com](http://www.PediatricDentistNH.com)) and click on the *Payment Options* page and follow the easy instructions.

3. CareCredit – a financing plan to allow low monthly payments

We are excited to offer CareCredit, a new monthly payment plan. CareCredit is backed by GE and allows flexible financing options, *including no interest plans*. To make your payments over time, please visit [www.CareCredit.com](http://www.CareCredit.com) or call our office for more information. You can apply on the CareCredit website or you may come to our office to complete the simple, brief application. If you qualify, please notify our office.

## **Dental Insurance**

As you may realize, dental insurance benefits are often difficult to understand. To better explain some of the facts, we compiled an informative page on our website. We suggest that you visit the *Office Policies* page and read under the *Financial Provisions and Insurance* heading. Many of our parents have found this information very useful and easy to understand.

We appreciate the confidence you place in our office for your family's dental care.  
We look forward to seeing you at your next appointment.

**[www.PediatricDentistNH.com](http://www.PediatricDentistNH.com)**