Rockingham Pediatric Dental
32 Stiles Rd. Suite 207 Salem, NH 03079
Phone 603-898-8611

CONFIDENTIAL

Patient Information

Child's Name: _____ Preferred/Nickname: _____

Gender: ◯ Male ◯ Female Birthdate: _____ School: _____

Address: _____ Zip: _____ Phone: _____

First language: _____ Is this your child's first dental visit? ◯ Yes ◯ No

If "no", name of former dentist: _____ Date of most recent x-rays, if applicable: _____

If doctor recommends, may we have your permission to take dental x-rays today? ◯ Yes ◯ No

Have any other children in your family been a patient in this office before? ◯ Yes ◯ No

Name(s) and age(s) of siblings: _____

Do you have any issues or concerns regarding your child's dental health that you would like addressed?

_____

Has your child had any negative dental experiences? _____

If yes, please explain: _____

_____

Whom may we thank for referring you to our office? _____

Patient's Mother's/Guardian's Full Name: _____ Birthdate:_____

Address: _____ Zip:_____ Phone: _____

Social Security #: _____ Marital Status: _____ Occupation: _____

Cell Phone: _____ Business Phone: _____

E-mail Address: _____ Preferred Contact Number: ◯ Home ◯ Cell ◯ Work

Patient's Father's/Guardian's Full Name: _____ Birthdate: _____

Address (if different): _____ Zip: _____ Phone: _____

Social Security #:_____ Marital Status: _____ Occupation: _____

Cell Phone: _____ Business Phone: _____

E-mail Address: _____ Preferred Contact Number: ◯ Home ◯ Cell ◯ Work

Child lives with: ◯ Both Parents ◯ Mother ◯ Father ◯ Other

Person Responsible for Billing: _____ Relationship: _____

Emergency Contact Person(Other than Parent): _____

Phone Number: _____ Relationship: _____