JEFFREY R. McKECHNIE, DMD • CHRISTOPHER P. ALTADONNA, DDS

P. O. BOX 1543 • STOWE, VT. 05672 • 802/253-7932

Child's Information:

Today's Date:_____
Child's Name: _____
Date of Birth:_____ Sex:_____
SS#:_____
Home Address:_____
City:_____
State:_____ Zip Code:_____
Home Phone Number:_____
Name of School:_____

Mother's Information:____

Name:_____
Address if Different from Child's:
_____
City:_____
State:_____ Zip Code:_____
Date of Birth:_____
SS#:_____
Work Phone Number:_____
Cell Phone Number:_____
Employer:_____
Email:_____

Father's Information:

Name:_____
Address if Different from Child's:
_____
City:_____
State:_____ Zip Code:_____
Date of Birth:_____
SS#:_____
Work Phone Number:_____
Cell Phone Number:_____
Employer:_____
Email:_____

Who is responsible for payments?

Name:_____
Address & Telephone Number if different from above:
_____
_____
_____
_____

Primary Dental Information

Insured Name:_____
Relationship to Insured Name:_____
Employer:_____
Address:_____
City:_____ Zip Code:_____
Phone Number:_____
Insurance Company:_____
Address:_____
City:_____ Zip Code:_____
Phone Number:_____
Group Number:_____
SS#:_____ ID#:_____

Secondary Dental Information:

Insured Name:_____
Relationship to Insured Name:_____
Employer:_____
Address:_____
City:_____ Zip Code:_____
Phone Number:_____
Insurance Company:_____
Address:_____
City:_____ Zip Code:_____
Phone Number:_____
Group Number:_____
SS#:_____ ID#:_____

Additional Notes:

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Health Information

Your child's overall health as well as any medications your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits? Y N

Comments:_____

_____

_____

Has your child ever had any of the following:

Asthma……Y……..N
HIV/AIDS……Y……..N
Diabetes……Y……..N
Rheumatic Fever……...Y……..N
Handicaps/Disabilities……..Y……..N
Tuberculosis……..Y……..N
Heart Murmur……Y…….N
Type:_____
Cancer/Hepatitis……Y……..N
Hemophilia……Y……..N
Allergies……Y……..N
Congenital Heart Defects……..Y……...N
Convulsions/Epilepsy……Y……..N
Abnormal Bleeding……Y……..N

Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Y N

Has your child ever taken Fen-Phen/Redux? Y N

Please explain any medical problems that your child has._____

_____

_____

Child's Habits

How often does your child brush?_____

How often does your child floss?_____

Date of last dental visit?_____

Previous Dentist Name, Address & Phone Number:_____

_____

Child's Physician:_____

Address & Phone Number:_____

_____

Is your child's water fluoridated? Y N

Does your child take fluoride supplements? Y N

Does your child:

- ❖ Suck thumb/finger Y N
- ❖ Suck / bite lips Y N
- ❖ Bite / chew nails Y N
- ❖ Chew hard objects (pencils, etc) Y N
- ❖ Grind teeth Y N
- ❖ Clench jaws Y N

Authorization & Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient's parent or guardian