MASCOMA DENTAL ASSOCIATES

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date:____________________________

Name(LAST,FIRST,MI):________________________

Nickname:_______________________________

Male: ____________Female: ______________

Birthdate:_____/_____/_____ Age:_________

School: ______________________Grade:____

Child's Home Address: ___________________

____

Home #:_________________________________

Email Address: ___________________________

Who Is Accompanying The Child Today?

Name: _________________________________

Relation:________________________________

Do you have legal custody of this child?_____

Person Responsible for Account: ___________

Billing Address: _________________________

____

Person Responsible for making appointments:

____

Guardian's Information

Guardian's Name: ___________________________

Birthdate: ___/___/___ Relation: ______________

Mobile#: _____________________________________

PREVIOUS DENTAL OFFICE INFORMATION

Previous Dentist:____________________________

Dental Office Phone #: ________________________

Last Visit Date: ______________________________

***REMINDER* If you haven't had your x-rays emailed to us please do so to kristen@mascomadental.com**

Do they have a personal physician? __________

Physician's Name: _________________________

Phone #_________________________________

Date of last visit:__________________________

Are they currently under the care of a physician?

____

Please Explain:

____

____

Why did you bring the child to the dentist today? ___________________________________
____

Has the child ever had a serious/difficult problem associated with previous dental work? ___________________________________

Is the child's water fluoridated? ____________

Is the child taking fluoride supplements? _____

Has the child ever had any pain/ tenderness in his/ her jaw joint (TMJ/ TMD)?_____________

Does the child brush his/her teeth daily?_____

Floss his/her teeth daily? __________________

Has your child ever taken Fosamax, or any other bisphosphonate? ___________________

Has your child ever taken Phen-Fen? _________

Please list all drugs that the child is currently taking: __________________________________
____

Please list all drugs/materials that the child is allergic to: ______________________________
____

Does/did the child have any of the following habits?

___ Lip Sucking/Biting
___ Nail Biting
___ Nursing Bottle Habits
___ Thumb/Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Has the child ever had any of the following medical problems?

___ Abnormal Bleeding
___ ADD/ADHD
___ Allergies to any drugs
___ Any Hospital Stays
___ Any Operations
___ Artificial Bones/Joints/Valves
___ Asthma
___ Cancer
___ Congenital Heart Defect
___ Convulsions/Epilepsy
___ Diabetes
___ Handicaps/Disabilities
___ Hearing Impairment
___ Heart Murmur
___ Hemophilia
___ Hepatitis
___ HIV+/AIDS
___ Kidney/Liver Problems
___ Rheumatic/Scarlet Fever
___ Sickle Cell Disease/Traits
___ Tuberculosis (TB)

Please discuss any serious medical problems that the child has had: ___________________
____
____

Neighbor or Relative not living with you.

Name: ______________Phone:__________________

Address: ___________________________________
____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials: _______________ Date: ________________________

Doctors Comments: __________________________________
____
____
____

Medical History Update

Date: __________ Signature: __________________
Date: __________ Signature: __________________
Date: __________ Signature: __________________
Date: __________ Signature: __________________
Date: __________ Signature: __________________
Date: __________ Signature: __________________
Date: __________ Signature: __________________