Mascoma Dental Associates

Dental Care Sensitive to Your Needs

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you!

ABOUT YOU

Today's Date:_____

Name(LAST,FIRST,MI):_____

I prefer to be called:_____

Male: _____Female: _____

Birthdate:_____/_____/_____ Age:_____

Mailing Address: _____

_____

Home #:_____

Mobile #: _____

Work #: _____

Email Address: _____

Employer: _____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us? _____

_____

In the event of an emergency, is there someone that we should contact?

His/Her Name:_____

Relation: _____ Phone #: _____

SPOUSE INFORMATION

His/Her Name: _____

Birthdate: ____/_____/_____

Mobile#: _____

Employer: _____

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 you have a personal physician? _____

Physician's Name:

_____

Phone #_____

Date of last visit:_____

Are you currently under the care of a physician?

_____

Explain: _____

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Art. Bones/Joints/ Valves	Y	N	Hospitalized for any reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease (STD)

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD: _____

_____

Are you taking any prescription/over-the-counter or herbal supplement drugs? Please List:

_____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? _____

Have you ever taken Phen-fen?

FOR WOMEN: Are you using a prescribed method of birth Control? Y N

Are you Pregnant? Y N

Are you Nursing? Y N

Are you **allergic** to any of the following?

Y	N	Aspirin
Y	N	Codeine
Y	N	Dental Anesthetics
Y	N	Erythromycin
Y	N	Jewelry
Y	N	Latex
Y	N	Metals
Y	N	Penicillin
Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and, treatment with my informed consent.

_____

Signature Date

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments:_____

_____

_____

_____

_____