Mascoma Dental Associates

2 Campbell Street
Lebanon, NH 03766
603-448-4200

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 (LAS, ,FIRST, MI):_____

Nickname: _____

Male: _____ Female: _____ Other: _____

Birthdate: _____/_____/_____ Age: _____

School: _____Grade:____

Child's Home Address: _____

_____

Home #: _____

Email Address: _____

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 frontdesk@mascomadental.com**

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:

_____

Do they have a personal physician? _____

hysician'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: _____