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: __________________________________