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: _____

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**

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? _____

Physician's Name: _____

Phone #_____

Date of last visit:_____

Are they currently under the care of a physician?

_____

Please Explain:

_____

_____