OLIVIA MASRY D.D.S. & JOYCE LOCKWOOD D.D.S., P.C.

312 CHAPPAQUA ROAD

BRIARCLIFF MANOR, NY 10510

Patient Name_____DOB_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

Name of Responsible Party_____

Billing Address_____

Employer Name_____

Address_____

Referred By_____

Medical History

Does your child have a history of?

- ☐ Diabetes
- ☐ Heart ailment
- ☐ Asthma
- ☐ Kidney disease
- ☐ Rheumatic fever
- ☐ Nervous system disorders
- ☐ Blood disorders
- ☐ Emotional/psychiatric disorders

Any other diseases or disorders?_____

Does your child have allergies? If so, please list_____

Does your child take any medications?_____

Has your child ever been hospitalized?_____

Has your child ever had any surgery?_____

Name of physician_____

Dental History

Please check all that apply

- ☐ Is this your child's first visit to the dentist?
  If not, when and where was his/her last visit?_____
- ☐ Does your child eat between meals?
- ☐ Does your child eat or drink sweets such as soda, Gatorade or juice?
- ☐ Does your child brush after breakfast?
- ☐ Does your child brush before bedtime?
- ☐ Do you have fluoridated water at home?
- ☐ Have there ever been any injuries to your child's teeth?

PARENT/GUARDIAN'S SIGNATURE_____ Date_____