Cooke, Richardson & Overtsreet, D.D.S.

Child Dental Registration & History

1. Patient Information

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Nickname: _____

Date of Birth: _____ Sex: _____ Male _____ Female

Social Security Number: _____

Address: _____
City: _____
State: _____ Zip Code: _____

School Name: _____ School Phone: _____

Person Financially Responsible: _____

Home Phone Number: (_____) _____-_____
Work Phone Number: (____) _____-_____
Cell Phone Number: (____) _____- _____
E-Mail: _____

Whom may we think for referring you? _____

2. Phone Numbers

Home: (____) _____-_____
Work: (____) _____-_____
Cell: (____) _____-_____
Other: (____) _____-_____
E-Mail: _____

IN CASE OF AN EMERGENCY: PLEASE GIVE TWO CONTACT NAMES (SPECIFY MOTHER/FATHER AND SOMEONE THAT DOES NOT LIVE IN YOUR HOUSEHOLD)

Name: _____
Relationship to Patient: _____
Home Number: _____
Work Number: _____
Cell Number: _____

Name: _____
Relationship to Patient: _____
Home Number: _____
Work Number: _____
Cell Number: _____

3. Dental Insurance

Subscriber's Name: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____) _____-_____
Work Phone Number: (_____) _____-_____
Cell Phone Number: (_____) _____-_____

E-Mail Address: _____

Employer: _____

Do you have dental coverage for this minor/child? _____

Insurance Company Name: _____

Address:_____
_____

Phone Number to Insurance Company: (_____) _____-_____

Group Number: _____

Policy / ID Number: _____

Secondary Insurance:

Subscriber's Name:_____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____) _____-_____
Work Phone Number: (_____) _____-_____
Cell Phone Number: (_____) _____-_____

E-Mail Address: _____

Employer: _____

Do you have dental coverage for this minor/child? _____

Insurance Company Name: _____

Address:_____
_____

Phone Number to Insurance Company: (_____) _____-_____

Group Number: _____

Policy / ID # Number: _____

4. Dental History

Date of last visit to a dentist: _____ For what services?_____

Has your child complained about dental problems? _____

Does child brush teeth daily? _____

Does child use floss every day? _____

Is fluoride taken in any form? _____

Any injuries to mouth, teeth or head? _____ If yes, explain: _____

Any unhappy dental experiences? _____

Any mouth habits? (Please circle) thumb sucking, nail biting, mouth breathing, pacifier or sleeping with a bottle?

5. Medical History

Minor/Child's Physician: _____

City: _____ State: _____

Phone Number: (____) _____-_____

Date of last physical examination: _____ Results: _____

Is Minor/Child under the care of physician now? _____

Receiving any medications or drugs? _____

Ever been hospitalized? _____ If yes, explain: _____

Is there excessive bleeding when cut? _____

Medications: _____
_____

Allergies: _____
_____

Has Minor/Child had any history of or difficulty with any of the following? If yes, please check.

__ AIDS/HIV	__ Diabetes	__ Liver Disease
__ Anemia	__ Drug/Alcohol Abuse	__ Measles
__ Asthma	__ Epilepsy	__ Mononucleosis
__ Bladder Problems	__ Fainting	__ Mumps
__Cancer	__ Hearing Problems	__ Rheumatic fever
__Cerebral Palsy	__ Heart Problems	__ Sinus Troubles
__ Chicken Pox	__ Hepatitis	__ Thyroid Disease
__ Convulsions	__ Kidney Disease	__ Tuberculosis

Other:
_____
_____
_____

6. Assignment and Release of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
(Name of Insurance Company)
Drs. Cooke, Richardson & Overstreet all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative:

_____
Please print name of Patient, Parent, Guardian or Personal Representative:

_____ _____
Date Relationship to Patient

7. Additional information:

Is there any additional information you would like to share with our office? Hobbies, interests, etc?

_____
_____
_____
_____

8. Thank you for taking this time to fill out our patient information sheet. We look forward to assisting you and your family with your dental health needs.