Debra Cook, DDS, MS

Cook Orthodontics

We would like to welcome you to our office.
Please complete both sides of this form. All information is confidential. Thank you.

Patient Information

Date _____
Patient's First Name _____ Last Name _____ Middle Name _____
Address _____ City _____ State ___ Zip Code _____
Home Phone(___)_____ Birth Date _____Age___Social Security # _____
If Patient Is A Minor, Give Parent or Guardian's Names _____
School_____ Grade_____ Age and Name of Other Siblings:_____
Whom May We Thank For Referring You To Our Office?_____

Responsible Party

First Name _____ Last Name _____ MI____ Marital Status ____
Address _____ City _____ State ___ Zip _____
Mailing Address_____
How Long At This Address_____Home Phone (___)_____Work Phone (___)_____
Email Address _____
Previous Address (if less than 3 yrs.) _____
Social Security # _____ Birth Date_____ Relationship to Patient _____
Employer_____Occupation _____ No. Years Employed ____

Spouse's Name _____ Last Name _____MI ____Work Phone(___)_____
Social Security # _____ Birth Date_____ Relationship to Patient _____
Employer_____Occupation _____ No. Years Employed ____

Dental Insurance Information

Insured's Full Name_____Soc. Sec. #_____ Date of Birth_____
Insurance Company _____Group No. _____ Local No _____

Insurance Complete Address and Phone # _____

Do you have dual coverage? Yes ☐ No ☐ If yes, please fill below:
Insured's Full Name_____ Soc. Sec. # _____
Insurance Company _____ Group No_____ Local No_____
Insurance Company Complete Address and Phone #:_____
Insured's Employer _____ Date of Birth_____

Emergency

Name Of Nearest Relative Not Living With You _____
City State and Zip_____Phone(___)_____

I Understand That Where Appropriate, Credit Bureau Reports May Be Obtained.

Signature *(Parents Signature If Patient Is A Minor)*_____

Medical And Dental History

Patient's Dentist _____ Last Dental Visit _____

Do you Need A Referral To A Dentist: _____

What Concerns Would You Like Orthodontics To Accomplish? _____

Indicate The Patient's Feeling Towards Orthodontic Treatment _____

Has An Orthodontist Been Previously Consulted? _____

Are Antibiotics Necessary For Teeth Cleanings? _____

Is There Any Dental Work That Needs To Be Completed Prior To Orthodontic Treatment? _____

Physician _____ Last Physical Exam _____

Is The Patient Under The Care Of A Physician At This Time? Please Explain _____

List Any Medications Being Taken At This Time _____

List Any Drugs/Thing That The Patient Is Allergic To Or Has A Reaction To _____

Has The Patient ever Had Any Of The Following Medical Problems?

Abnormal Bleeding	Yes	No	Aid/Hiv+	Yes	No	Diabetes	Yes	No
Plastic/Metal Allergy	Yes	No	Heart Problems	Yes	No	Asthma	Yes	No
Latex Allergy	Yes	No	Cancer or Tumor	Yes	No	Hepatitis	Yes	No
Epilepsy/Convulsions	Yes	No	Fainting or Dizziness	Yes	No	Anemia	Yes	No
Thyroid Problems	Yes	No	Pregnant Now	Yes	No	Tuberculosis	Yes	No
Kidney/Liver Problems	Yes	No	Hemophilia	Yes	No	Disabilities	Yes	No
Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Finger/Thumb Sucking	Yes	No	Cavities Now	Yes	No	Mouth Breathing	Yes	No
Tooth/Jaw Trauma	Yes	No	Smoke/Chew Tobacco	Yes	No	Headaches	Yes	No
Lip/Tongue Biting	Yes	No	Missing Permanent Teeth	Yes	No	Tongue Thrust	Yes	No
Tonsils/Adenoid Problems	Yes	No	Clenching Or Gringing	Yes	No	Extra Teeth	Yes	No

Please Explain Any Medical Or Dental Condition That Is Not Mentioned Above? _____

_____

Do You Have Any Disease Or Medical Or Dental Condition That Is Not Mentioned Above? _____

AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

_____ _____

Signature Patient / Parent / Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient/parent/guardian and patient named herein.

Signed: _____ Date _____

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