COOK FAMILY DENTISTRY
321 4TH St SE
Auburn, WA 98002
Dr. Amy Cook

Welcome to our office

Patient Registration

PATIENT NAME_______________________________________ I prefer to be called: _______________________
Mr Mrs Ms Dr
Gender: M F Date of Birth _______________ Age _______ Social Security # ________________
Home # _________________ Work # _________________ Cell # _________________ Best time to call ___________
Email address ____________________________________ Preferred method of contact ______________________
Address____City____________________________Zip____________
Marital status: ____________ Employer ___________________________ Occupation_________________________

Whom may we thank for referring you? ____
Other family members seen by us:____
Spouse's name:_____________________ Date of Birth_______________ Employer______________________

Person financially responsible for this account: ____
With whom may we discuss dental treatment and billing obligations? ____________________________________

PRIMARY INSURANCE
Insurance Company__________________________ Address ______________________ Phone #_________________
Subscriber's name__________________________ Patient relation to subscriber______________________________
Subscriber's date of birth____________ Subscriber's Social Sec # ______________ ID #________________________
Subscriber's employer_______________________________ Group # (Plan, Local, or Policy #) _________________

SECONDARY INSURANCE
Insurance Company__________________________ Address ______________________ phone #_________________
Subscriber's name__________________________ Patient relation to subscriber______________________________
Subscriber's date of birth____________ Subscriber's Social Sec # ______________ ID #________________________
Subscriber's employer_______________________________ Group # (Plan, Local, or Policy #) _________________

EMERGENCY CONTACT
Name: __________________________**Phone #:** __________________**Relation to patient** _______________________

DENTAL HISTORY

Reason for today's visit____
Date of last dental visit______________ Date of last dental X-rays________________

Please circle any that apply to you:

Bad breath	Clenching/grinding	Loose teeth or fillings
Bleeding gums	Dry Mouth	Orthodontics/braces
Blisters on lips or mouth	Food collection between teeth	Periodontal treatment

Do you have problems with your jaw? Yes No Pain Clicking Popping Which side? Right Left Both
Do your use tobacco? Chewing Pipe Cigar Cigarette Other (please describe): _________________________
Do you have sensitivity? Yes No Sweets Pressure/Biting Temperature: Hot Cold Sweets Other: ___________

HEALTH HISTORY

Physician's name______________________________ City________________Phone_________________________
Pharmacy____________________________________ City ________________ Phone________________________

Please circle any that apply to you:

AIDS/HIV	Diabetes type I or type II	Shortness of breath
Anemia	Emphysema	Sinus Trouble: Right Left
Arthritis	Epilepsy	Stroke
Artificial heart valves	Heart problems	Swollen gums
Asthma	Hepatitis Type: _____	Swollen feet/ankles
Bleeding abnormally	Joint replacement	Swollen neck glands
Blood pressure: High Low	Kidney disease	Tumor or growth on head/neck
Cancer	Liver disease	Ulcer or acid reflux
Congenital/birth defect of the heart	Pacemaker	Weight loss (unexplained)
Cough, persistent or bloody	Radiation to head/neck	Other:

Do you have frequent headaches? YES NO Morning Daytime Random times Migraines Other: ________
Have you had a sleep study? YES NO Results of sleep study: _____________________________________

CURRENT MEDICATIONS (please list ALL medications)
Please tell us of any medication changes at every appointment. If you take multiple medications, we would be happy to photocopy a list for your chart.

ALLERGIES (please list ALL allergies, including those to foods and substances like latex)

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

____ ________________________________
Signature date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

03/2017