Child form

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

Welcome to our office

Patient Registration

Child's NAME____ I prefer to be called: ________________________
Gender: M F Date of Birth____________ Age: ________ School District/Grade: __________________________
Address_____________________________________ City____________________State/Zip_____________________
Sports/Hobbies ____
How did you hear about us or whom may we thank for referring you? ____________________________________

Who is accompanying your child today? _____________ Do you have legal custody of this child? Yes No
Person financially responsible for this account: ____
With whom may we discuss dental treatment and billing obligations? ____________________________________

MOTHER'S INFORMATION stepmother guardian
Name____
Employer____
Job title____
Home #______________________________
Birthdate______________________________
Work#_______________________ext______
Cell #_________________________________

FATHER'S INFORMATION stepfather guardian
Name____
Employer____
Job title____
Home #______________________________
Birthdate______________________________
Work#_______________________ext______
Cell #_________________________________

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 your child:

Bad breath	Dental fears/bad experiences	Injury to face or mouth
Bleeding gums	Discoloration	Loose teeth/fillings
Blisters on lips or mouth	Dry Mouth / Mouth breathing	Orthodontics/braces treatment
Cavities	Food collection between teeth	Sensitivity to cold/hot/sweets/biting
Cigarette/chewing tobacco	Grinding	Thumb/finger sucking
Click/pain/pop in jaw: Right Left	Injury to head or neck	Other:

HEALTH HISTORY

Physician's name_____________________________ City________________ Phone________________________

Pharmacy___________________________________ City ________________ Phone_______________________

Please circle any that apply to your child:

Adenoidectomy	Cough, persistent or bloody	Swollen gums
ADHD/ADD	Diabetes type I or type II	Swollen neck glands
Artificial heart valves	Epilepsy	Tonsillectomy
Asthma	Headaches	Trouble sleeping
Autism spectrum	Heart problems	Tumor or growth on head/neck
Bleeding abnormally	Hepatitis	Reflux
Cancer	Radiation to head/neck	Weight loss (unexplained)
Concussion	Sinus trouble Right Left	Other:
Congenital/birth defect of the heart	Frequent sore throat	

CURRENT MEDICATIONS (please list ALL medications)

Please tell us of any medication changes at every appointment.

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 relation to patient date

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

03/2017