DR. BETH COOK

Pediatric Dentistry of South Charlotte

Specializing in dental care for infants, children and adolescents

New Patient Registration

Welcome to our office! Careful completion of this form will assist us in providing your child with the best possible dental care.

1. Tell Us About Your Child

Child's Full Name ______________________ Prefers to be called ______________ Today's Date ___/___/_____

Date of Birth ___/___/_____ Age ____ [ ] Male [ ] Female Names and ages of siblings ______________________

Home address ______________________ Parents' Marital Status [ ] M [ ] S [ ] D [ ] Sep [ ] W

City ______________ State ____ Zip _________ School ______________________ Grade _________

Home Phone ______________________ How did you hear about us? ______________________

2. Parent 1 Information

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other ______________

Name ______________________ Prefers to be called ______________ Date of Birth ___/___/________

Address [ ] Same as child's ______________________ Occupation ______________________

City ______________ State ____ Zip _________ Work Phone ______________________

Home Phone ______________________ Email ______________________

Cell Phone ______________________ Preferred method of contact ______________________

Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

3. Parent 1 Information

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other ______________

Name ______________________ Prefers to be called ______________ Date of Birth ___/___/________

Address [ ] Same as child's ______________________ Occupation ______________________

City ______________ State ____ Zip _________ Work Phone ______________________

Home Phone ______________________ Email ______________________

Cell Phone ______________________ Preferred method of contact ______________________

Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

4. **Person Responsible for This Account**

Name ______________________ Relationship ______________________

Billing Address [ ] See Above______________________ Home Phone ______________________

City ______________ State ____ Zip _________ Work Phone ______________________

5. **Dental Insurance Information (If Applicable)**

Primary Insurance Co. Name ______________________ Insurance Co. Phone ______________

Insurance Co. Address ______________________ Group# ______________ Policy# ______________

City ______________ State ____ Zip _________ Social Security # ______________________

Policy Owner's Name ______________________ Policy Owner's Employer ______________________

Relationship to Patient ______________________ Policy Owner's Birthdate [ ] See Above ____/____/_______

Secondary Insurance Co. Name ______________________ Insurance Co. Phone ______________

Insurance Co. Address ______________________ Group# ______________ Policy# ______________

City ______________ State ____ Zip _________ Social Security # ______________________

Policy Owner's Name ______________________ Policy Owner's Employer ______________________

Relationship to Patient ______________________ Policy Owner's Birthdate [ ] See Above ____/____/________