

Cooper Orthodontics

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Adult Registration Form: Please complete the following:

Today's date: _____ Email Address: _____

NAME: _____ Prefer to be called: _____

Birthdate: _____ Male ___ Female ___ SS#: _____

Home Address: _____

_____ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Home Phone #: _____ Cell#: _____

Work Phone#: _____

Employer: _____

Address: _____

How long there? _____ Occupation: _____

Whom may we Thank for referring you: _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

SPOUSE INFORMATION:

His/Her name: _____

Employer: _____

Work phone #: _____

Birthdate: _____

Person Responsible for Account:

Name: _____

Billing Address: _____

Home Phone#: _____ WorkPhone#: _____

Relation: _____ SS#: _____

Orthodontic Insurance

Do you have orthodontic coverage? _____ Yes _____ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group#: _____

Insured's Name: _____

Insured's Birthdate: _____ Relation: _____

Insured's Employer: _____

We file secondary insurance to pay directly to the insured party. We do not accept assignment on secondary insurance.

Signature

DATE