

Cooper Orthodontics

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Child's Registration Form: Please fill in the following:

Patient's Name: _____ Date of Birth: _____

Home Address: _____ SEX: M F SS#: _____

City: _____ Zip: _____ Home Phone: _____

Mother's name: _____ Occupation: _____

Marital Status: S_ M_ D_ W_ Employer: _____ Yrs. Employed: _____

SS#: _____ Work Phone#: _____

Father's name: _____ Occupation: _____

Marital Status: S_ M_ D_ W_ Employer: _____ Yrs. Employed: _____

SS#: _____ Work Phone#: _____

Person Responsible for account: _____ Relationship to patient: _____

Address & SS# of responsible party(if different from above): _____

Name & Ages of other siblings: _____

How did you hear about our office: _____

General Dentist: _____ Date of last check-up: _____

Do you have orthodontic insurance coverage? Yes _____ No _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Policy Owners Name: _____ Relationship to patient: _____

Policy Owner Birthdate: _____ Policy Owner Employer: _____

Should you have secondary insurance, we will file claims to pay directly to the insured party: We do not accept payments on secondary insurance!

DATE: _____ Signature: _____