COOK DENTISTRY

609 W. South St. / Mason MI 48854

Patient: _____

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Single Dental Insurance

◯ Dual Dental Insurance

Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Secondary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Insurance Authorization and Assignment of Benefits: *I hereby authorize the release of any dental or other information necessary to process my insurance claims. I also request and authorize payment of dental benefits directly to Dr. Corey Cook, DDS for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I also acknowledge that I am responsible for any deductibles, co-payments, co-insurance, or non-covered services determined by my insurance plan.*

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DENTAL HISTORY

Name of previous dental office: _____

Date of last dental visit: _____

How often do you floss? _____ How often do you brush? _____

Check if you have had problems with any of the following:

- ◯ Bad Breath
- ◯ Bleeding gums
- ◯ Grinding teeth
- ◯ Periodontal treatment
- ◯ Loose teeth or broken fillings
- ◯ Sensitivity to sweets
- ◯ Sensitivity when biting
- ◯ Sensitivity to cold
- ◯ Sensitivity to hot
- ◯ Food collections between the teeth
- ◯ Sores or growths in your mouth
- ◯ Clicking or popping jaw

MEDICAL HISTORY

Please check all that apply

- ___ Anemia
- ___ Arthritis
- ___ Artificial Heart Valve
- ___ Artificial Joints, Pins, etc.
- ___ Asthma
- ___ Back Problems
- ___ Bleeding Abnormally
- ___ Blood Disease
- ___ Cancer
- ___ Chemical Dependency
- ___ Chemotherapy
- ___ Circulatory Problems
- ___ Congenital Heart Lesions
- ___ Coritson Treatment
- ___ Cough - Persistent
- ___ Cough up Blood
- ___ Diabetes
- ___ Epilepsy
- ___ Fainting
- ___ Glaucoma
- ___ Headaches
- ___ Heart Murmur
- ___ Heart Problems
- ___ Hemophilia
- ___ Hepatitis
- ___ Hernia Repair
- ___ High Blood Pressure
- ___ HIV/AIDS
- ___ Jaw Pain
- ___ Kidney Disease
- ___ Liver Disease
- ___ Mitral Valve Prolapse
- ___ Pacemaker
- ___ Radiation Treatment
- ___ Respiratory Disease
- ___ Rheumatic Fever
- ___ Scarlet Fever
- ___ Shortness of Breath
- ___ Skin Rash
- ___ Stroke
- ___ Swelling of Feet/Ankles
- ___ Thyroid Problems
- ___ Tobacco Use
- ___ Tonsilitis
- ___ Tuberculosis
- ___ Ulcer
- ___ Vernereal Disease

Primary Care Provider Name: _____

Primary Care Provider Phone Number: _____

Date of last visit with primary care: _____

Have you had any serious illness/operation? ◯ Yes ◯ No If yes, please explain: _____

_____

Have you had a blood transfusion? ◯ Yes ◯ No If yes, give approximate dates: _____

Are you pregnant? ◯ Yes ◯ No

Are you currently nursing? ◯ Yes ◯ No

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Are you currently taking a blood thinner? ◯ Yes ◯ No If yes, which one? _____

Have you been diagnosed with Osteoporosis? ◯ Yes ◯ No If yes, are you currently receiving treatment? ◯ Yes ◯ No

Please list all medications you are currently taking and the correlating diagnosis :

_____

_____

_____

_____

_____

Please list all known allergies:

_____

_____

_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature Date