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 ____/____/_____