



## Cook & Mess Orthodontics

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*Specialists in Orthodontics*

### General Information

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Nickname \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Sex  Male  Female Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Residence Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Who is Responsible for this account? \_\_\_\_\_ Relationship \_\_\_\_\_

Father's Full Name \_\_\_\_\_

Address (if different than patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Do you have insurance coverage for orthodontics? Y / N Dental Insurance Co. \_\_\_\_\_

Social Security/I.D. No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Email Address \_\_\_\_\_

Father Employed by \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Address (if different than patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Do you have insurance coverage for orthodontics? Y / N Dental Insurance Co. \_\_\_\_\_

Social Security/I.D. No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Email Address \_\_\_\_\_

Mother Employed by \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

### Child's History (These questions are of great value in aiding us to better understand your child.)

1. Is your child in good health? \_\_\_\_\_

2. Is your child mentally alert? \_\_\_\_\_

3. Does your child have any history of heart trouble, allergies, cerebral palsy or infectious diseases? \_\_\_\_\_

4. Has your child had favorable reactions to previous dental or medical care? \_\_\_\_\_

Child's Physician \_\_\_\_\_

Child's Dentist \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_