Cox Pediatric Dentistry, P.C.
3145 Virginia Beach Blvd. (Suite 200)
Virginia Beach, VA 23452

Patient Registration Forms

Tell us About your Child

Child's Name (Last, First, MI): ________________ Preferred Name: ________________ ☐Male ☐ Female

Child's Date of Birth: ________________ Child's age: __________ School: ________________ Grade: __________

Child's Home Address: ________________ City: ________________ State: ________ Zip Code: __________

Child resides with (check all that apply): ☐Mom ☐Dad ☐Stepmom ☐Stepdad ☐Grandparent ☐Other: ________________

Who is Accompanying the Child Today?

Name: ________________ Relationship: ________________ Do you have legal custody of the child? ☐Yes ☐No

Emergency Contact Name: ________________ Phone: ________________ Relationship: ________________

Whom may we thank for this referral? ________________________________

Names and ages of other children in family? ________________________________

Person Responsible for Account

Mother's Information:

Name: ________________ DOB: ________________

Address: ________________________________

____

Employed by: ________________________________

Occupation: ________________________________

Business Phone #: ________________________________

Home Phone #: ________________________________

Cell Phone #: ________________________________

Email Address: ________________________________

Marital Status: ☐ Single ☐ Divorced ☐Married

☐ Married to:

Father's Information:

Name: ________________ DOB: ________________

Address: ________________________________

____

Employed by: ________________________________

Occupation: ________________________________

Business Phone #: ________________________________

Home Phone #: ________________________________

Cell Phone #: ________________________________

Email Address: ________________________________

Marital Status: ☐ Single ☐ Divorced ☐Married

☐ Married to:

Dental Insurance

Insurance Co. Name: ________________ Insurance Co. Phone #: ________________

Insurance Co. Address: ________________________________

Group #: ________________ ID, Plan or Policy #: ________________

Insured's Name: ________________ SS#: ________________ Insured's DOB: ________________

Insured's Employer: ________________ Relationship to Child: ________________

Authorization and Financial Responsibility Statement

I certify the truth of all information provided. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Thomas L. Cox, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all services provided. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care provider. I agree to pay for all costs of collection proceeding, including collection fee of 33.33% of the balance.

________________________________ ________________

SIGNATURE OF PARENT/GUARDIAN DATE

Child's Name: ____ **Date**: _______________________________

MEDICAL HISTORY:

1. Name of physician ____Phone # _____________________________

2. Has your child had a physical examination? When? ____

3. Is your child currently taking medication? What? ____

4. Has your child been hospitalized? If yes explain: ____

5. Has your child had a tetanus shot? When? ____

6. Is parent or patient pregnant? ____

7. Does your child have a habit? _____ Finger _____ Thumb ______ Pacifier _____ Other

7. Is your child allergic to any medicine or food? Explain: ____

8. Has your child had a history of any of the following? Please check a response for each question:

ADHD or ADD	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Autism/Asperger's/ Spectrum	☐ Yes	☐ No	Breathing Problems	☐ Yes	☐ No
Cancer or Tumor	☐ Yes	☐ No	Celiac Disease	☐ Yes	☐ No
Cerebral Palsy/development delay	☐ Yes	☐ No	Cleft lip/ palate	☐ Yes	☐ No
Congenital birth defects	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Down syndrome	☐ Yes	☐ No	Emotional/ psychological problem	☐ Yes	☐ No
Epilepsy, seizures or fainting	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No
Heart trouble/ disease	☐ Yes	☐ No	Hemophilia or bleeding problem	☐ Yes	☐ No
Hepatitis or liver problems	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	OCD/ ODD	☐ Yes	☐ No
Rheumatic or scarlet fever	☐ Yes	☐ No	Sensory issues	☐ Yes	☐ No
Sickle cell anemia/ blood disorder	☐ Yes	☐ No	Speech or hearing problems	☐ Yes	☐ No
Thyroid or glandular problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

Please list any other medical issues/concerns not listed above: ____

____

If you answered "Yes" to any of the above questions please Explain: _______________________________________

____

Does your child have any emotional or behavioral conditions not listed above? If "Yes" please explain: ____________

____

If you child has a heart condition do they need to be pre medicated? ☐ Yes ☐ No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Thomas L. Cox and his staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and or analgesia necessary to treat any dental/ oral deficiency, abnormality, and / or infection.

____ ________________________________

Signature of Parent/ Guardian Date