Howard F. Cooke, D.M.D., M.S.
Diplomate, American Board of Oral and Maxillofacial Surgery

WELCOME TO OUR PRACTICE!

Patient's First Name _____MI _____ Last Name_____

According HIPPA Compliance please circle whether or not we may leave a detailed message at each number provided.

Phone: Mobile(___)___-____(Y/N) Work:(___)___-_____(Y/N) Home: (___)___-_____(Y/N)

Email Address: _____ May we correspond by email? Circle one Y/N

Sex: M ❑ F ❑ Date of Birth: __/__/____ Age:__ SS#:___-__-____ DL#:_____

Address _____Apt:_____ City:_____ State:__ Zip:_____

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Employed: ❑Full Time ❑Part Time ❑Retired ❑Student

Medical Doctor _____ Dentist:_____

Orthodontist _____

Emergency Contact Name _____Number_____

Dental Ins Company	
Insured Name, DOB, SS#	
Relationship to Patient	❑Self ❑Spouse ❑Mother ❑Father ❑ Other
Employer	

Medical Ins Company	
Insured Name, DOB, SS#	
Relationship to Patient	❑Self ❑Spouse ❑Mother ❑Father ❑Other
Employer	

Person financially responsible for the account (if different than patient)									
Address		**Apt#**		**City**		**State**		**Zip**	

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.
Please list below the individual's whom you allow us to give your clinical information to or answer questions from:

Name/Relationship:_____

Name/Relationship:_____

_____ _____
Patient Signature (or legal guardian if minor) Date