Registration Form

Date _____

Patient Name_____ **Birthdate**_____
Name of Parent/Guardian (if under 18): _____

Street Address: _____ City: _____ State: ____ Zip: _____
Home #:_____ Cell #:_____ Work #:_____
Patient's SS#: _____ Patient's Employer: _____[ ]Single [ ]Married [ ]Divorced [ ]Widowed
Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Insurance:

Name of Insured:	Relationship to Patient [ ]Self [ ]Spouse [ ]Child
Insured SSN:	Insured DOB:
Subscriber ID:	Group #:
Employer:	Ins. Company:
Address:	Ins. Address:
City, State, Zip:	Ins. City, State, Zip:

Secondary Insurance:

Name of Insured:	Relationship to Patient [ ]Self [ ]Spouse [ ]Child
Insured SSN:	Insured DOB:
Subscriber ID:	Group#:
Employer:	Ins. Company:
Address:	Ins. Address:
City, State, Zip:	Ins: City, State, Zip:

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Enid Dental Care to release all information necessary to secure the payment of benefits.

Reason for today's visit: _____
Former Dentist: _____ Date of last dental visit/cleaning: _____
How often do you brush? _____ How often do you floss? _____

Yes[ ] No[ ] Have you lost any teeth?
Yes[ ] No[ ] Were replacements discussed for missing teeth?
Yes[ ] No[ ] Are you happy with the appearance of your teeth?
Yes[ ] No[ ] Are you interested in any cosmetic treatment (whitening, veneers, Botox, etc.)

PLEASE MARK (X) YOUR RESPONSES TO THE FOLLOWING:

Yes[ ] No[ ] Bad breath	Yes[ ] No[ ] Drink fluoridated water
Yes[ ] No[ ] Bleeding gums	Yes[ ] No[ ] Consume sugar products between meals
Yes[ ] No[ ] Blisters/Cold Sores	Yes[ ] No[ ] Earache/neckache
Yes[ ] No[ ] Clicking/popping/discomfort of Jaw	Yes[ ] No[ ] Bruxism (grinding of teeth)
Yes[ ] No[ ] Dry mouth	Yes[ ] No[ ] Wear dentures/partial
Yes[ ] No[ ] Sensitive to cold/hot/sweets/pressure	Yes[ ] No[ ] Loose teeth/broken fillings
Yes[ ] No[ ] History of orthodontics (braces)	Yes[ ] No[ ] Nervousness about dental treatment
Yes[ ] No[ ] History of Periodontal (gum treatment)	Yes[ ] No[ ]

Signature of Patient, Parent or Guardian

_____ **Date**_____