PATIENT REGISTRATION FOR REEL SMILES

Full Name _____ Date of Birth _____
Last First Middle

Mailing Address _____ Social Security # _____

City _____ State _____ Zip _____ Home Telephone _____

Email _____ Cell Phone _____

Employer _____ Business Phone _____

Spouse's Name (if married) _____ DOB _____ SS# _____

Parent's Name (if under 18) _____ DOB _____ SS# _____

Name of person responsible for payment _____

Purpose of this appointment? _____ Do you have dental insurance? _____

Whom may we thank for referring you? _____

HEALTH HISTORY QUESTIONNAIRE

	Yes	No
1. Date of last visit to your medical doctor Reason for last visit _____ Name of physician or clinic _____		
2. Have you ever been hospitalized, had an operation or serious illness? Please list _____	_____	_____
3. Are you taking any drugs or medicines? Please list _____	_____	_____
4. Are you allergic to any drugs, medicines, dental anesthetics, metals or latex? Please list _____	_____	_____
5. Have you ever needed special treatment due to excessive bleeding?	_____	_____
6. Do you use tobacco products? Please circle: Cigarettes (_____ per day) Pipe Chew Dip Other _____	_____	_____
7. Have you ever been told to take antibiotics before dental appointments because of medical condition?	_____	_____
8. If female; are you pregnant, taking birth control pills or taking bone density medication?	_____	_____

9. Have you ever had any of the following? (please circle)

Heart Trouble / Chest Pain	Artificial Joint	Hepatitis, Jaundice or Liver Disease
Heart Murmur	Asthma or Lung Disease	Kidney Disease
High Blood Pressure	AIDS	Convulsions, Epilepsy or Nervous Disorders
Rheumatic Fever	Venereal Disease	Cancer
Stroke	Blood Transfusion	Tuberculosis
Psychiatric Medication	Thyroid Trouble	Osteoporosis or Bone Density Problems
Diabetes	Cold Sores / Fever Blisters	

Any other medical condition _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will be responsible for informing this office at my next appointment.

Date	Signature of Patient or Parent	Staff/Dentist Signature