

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

REEL SMILES

OFFICE POLICY

REEL SMILES files insurance as a courtesy to our patients. You are responsible for insurance co-pays and deductibles at the time of service.

Your dental insurance is an agreement between you and your insurance company to pay a specified amount for dental care. The fees of this office are not based on the amount insurance will pay. The amount approved on a particular procedure by your insurance company may be more or less than the fees charged. Full payment for your treatment remains your exclusive financial responsibility, including charges not covered by your insurance company.

Payment is due forty-five (45) days after a claim has been submitted on your behalf. If you are unable to meet your obligation, please contact the business office.

This office cannot wait on payments pending any legal action involving the patient and third parties. (Auto accidents, workers comp., etc...)

Patients with no insurance are expected to make payment at the time of service unless other arrangements have been made with the business office.

APPOINTMENTS: We pride ourselves on seeing you as close to your appointment time as possible. This time is reserved exclusively for you. Appointments broken or cancelled without 24 hours notice are subject to a missed appointment fee.

AUTHORIZATION FOR "SIGNATURE ON FILE":

I, _____, hereby authorize the office of REEL SMILES to affix my name to any and all claims or documents as related to any and all health benefits due to me.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of REEL SMILES.

This "Signature on File" will be valid from this date. A photocopy of this document may act as an original.

I also authorize REEL SMILES to release all necessary information to secure payment of benefits from my insurance carriers.

Signature of Insured

Witness

PRIVACY POLICY

I have received a copy of this office's Notice of Privacy Practices.

Signature of Insured