

**PATIENT REGISTRATION**

PATIENT FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MI \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_

PATIENT IS: \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_ RESPONSIBLE PARTY

**RESPONSIBLE PARTY (If someone other than the patient)**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOC SEC # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVERS LIC # \_\_\_\_\_

IS RESPONSIBLE PARTY ALSO A POLICYHOLDER FOR PATIENT? \_\_\_\_\_ YES \_\_\_\_\_ NO

**PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

SEX: \_\_\_ MALE \_\_\_ FEMALE MARITAL STATUS: \_\_\_ MARRIED \_\_\_ SINGLE \_\_\_ DIVORCED \_\_\_ SEPARATED \_\_\_ WIDOWED

BIRTH DATE \_\_\_\_\_ SOC SEC # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVERS LIC # \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ Would you like to receive appointment reminders via this address? \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_ SELF \_\_\_ SPOUSE \_\_\_ CHILD \_\_\_ OTHER

INSURED SOC SEC # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ INSURED BIRTH DATE \_\_\_\_\_

NAME OF INSURANCE CO \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE ID/GROUP # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

DO YOU HAVE ANY SECONDARY INSURANCE COVERAGE? \_\_\_\_\_ YES \_\_\_\_\_ NO

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

NAME \_\_\_\_\_

**DENTAL HISTORY**

HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL CLEANING? \_\_\_\_\_

WHO WAS YOUR PREVIOUS DENTIST? \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH? \_\_\_\_\_ FLOSS? \_\_\_\_\_

TOOTHBRUSH TYPE? \_\_\_\_\_MANUAL \_\_\_\_\_ELECTRIC

WHAT TYPE OF TOOTHPASTE/MOUTHWASH DO YOU USE? \_\_\_\_\_

HAVE YOU EVER BEEN DIAGNOSED WITH ORAL CANCER? \_\_\_\_\_ YES \_\_\_\_\_NO

DO YOU EXPERIENCE PAIN IN YOU JAW (TMJ)? \_\_\_\_\_ YES \_\_\_\_\_NO

DO ANY OF YOUR TEETH HURT? \_\_\_\_\_ YES \_\_\_\_\_NO (If YES please indicate area of mouth and type of pain below)

AREA OF PAIN

\_\_\_\_\_UPPER RIGHT

\_\_\_\_\_UPPER LEFT

\_\_\_\_\_LOWER RIGHT

\_\_\_\_\_LOWER LEFT

**IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHAT WOULD IT BE?**

\_\_\_\_\_

**ARE YOUR TEETH SENSITIVE TO ANY OF THE FOLLOWING:** (circle the ones that apply to you)

HOT COLD BITING OR CHEWING SWEETS

**HAVE YOU EVER HAD:** (circle the ones that apply to you)

BRACES BITE GUARD PERIODONTAL TREATMENT (Gum surgery) ORAL SURGERY

SERIOUS INJURY TO MOUTH OR HEAD (Explain) \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING BEHAVIORS/HABITS IF THEY APPLY TO YOU**

GRIND TEETH

CIGAR/CIGARETTE

TOOTHPICK/STIMULATOR

BITE CHEEK

PIPE

CHEWING GUM

TONGUE THRUST

BITE NAILS

CANDY

MOUTH BREATHER

SMOKELESS TOBACCO

SOFT DRINKS

BULIMIA/ANOREXIA

THUMB/FINGER

OTHER \_\_\_\_\_

**HAVE YOU EVER BEEN REQUIRED TO TAKE ANTIBIOTICS/PRE-MEDICATION BEFORE ANY DENTAL TREATMENT?**

NO \_\_\_\_\_ YES \_\_\_\_\_ IF YES EXPLAIN \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## RECORDS RELEASE

DATE \_\_\_\_\_

DEAR DR. \_\_\_\_\_

I AM REQUESTING MY RECORDS BE MAILED OR EMAILED TO:

DR CHRIS MAFFETT

440 FOLLY ROAD

CHARLESTON, SC 29412

EMAIL DIGITAL XRAYs TO: **office@CharlestonsDentist.com**

THANK YOU FOR YOUR COOPERATION. IF YOU HAVE ANY QUESTIONS

PLEASE CALL 843-795-2727.

PATIENT NAME \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

## FINANCIAL POLICY

Dr. Chris Maffett

Thank you for choosing our office for your dental needs. To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

**PAYMENTS:** Payments are expected at the time services are rendered. We accept cash, checks, debit cards, Visa, MC, AMEX and Discover. By arrangement with CARE CREDIT, we offer our patients, upon credit approval, an interest-free loan (up to 6 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

**INSURANCE:** As a courtesy, our office will file your dental insurance for you. We will estimate what your insurance will pay and collect your portion or co-pay at each visit. We will do our best to give you an accurate estimate but please remember that it is just an ESTIMATE. All charges are the patient's responsibility regardless of any difference in our estimates and what the insurance actually pays. Our trained staff will gladly assist you in understanding your dental plan. Upon request, we will submit pre-treatment estimates to your insurance company for their pre-approval. This often takes several weeks and may not be possible for all treatment.

**BROKEN APPOINTMENTS:** To help our patients manage their busy schedules, we mail post-cards, send e-mails, and make phone calls to remind patients of upcoming appointments. We understand that sometimes things come up unexpectedly and appointments will have to be cancelled at the last minute. When possible please give us at least a 48 hour notice of any appointment changes or cancellations. Excessive cancelled or missed appointments will be charged a \$75 cancellation fee and may result in dismissal from the practice.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read Dr. Maffett's Financial Policy. I understand and agree to the terms of this policy.

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Signature of Patient or Responsible Party Date

I hereby authorize the release of all information from my records to insurance companies

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Signature of Patient or Responsible Party Date

I hereby authorize payment of all dental payments payable to me to go directly to the provider

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Signature of Patient or Responsible Party Date