**PATIENT REGISTRATION**

PATIENT FIRST NAME________________________________LAST NAME_______________________________________MI_______

PREFERRED NAME______________________________________

PATIENT IS: ______POLICY HOLDER _____RESPONSIBLE PARTY

**RESPONSIBILE 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 _____N0

**PATIENT INFORMATION**

FIRST NAME________________________________________LAST NAME________________________________________MI_______

ADDRESS__________________________________________________________________________________________________________

CITY, STATE, ZIP___________________________________________________________________________________________________

HOME PHONE______________________________WORK #______________________________CELL#_________________________

SEX: ___MALE ___FEMALE MARITIAL 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______________________________________________________________

## 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.

______________________________________________________________________________

Signature of Patient or Responsible Party Date

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

______________________________________________________________________________

Signature of Patient or Responsible Party Date

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

______________________________________________________________________________

Signature of Patient or Responsible Party Date

# 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?

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