Dental History

Reason for today's visit?_____

Date of Last Dental Care:_____ Date of Last X-ray:_____

Previous Dentist:_____

Address:_____

Check if you had any problems with any of the following:

__Bad Breath	__Grinding teeth	__Sensitivity to hot/cold	__Bleeding gums
__Loose Teeth	__Broken Fillings	__Sensitivity to sweets	__Clicking or popping jaw
__Periodontal Treatment	__Braces	__Spaces between teeth	__Sores in mouth

Do you Floss? _____How often do you brush? _____

_____

Medical History

Physician's Name:_____ Date of Physical: _____

Have you had any serious illnesses or operations? ___Yes ___ No If yes, Describe:_____

Have you ever had a blood transfusion? ___Yes ___No If yes, approximate date:_____

(Women) Are you pregnant? ___Yes ___No Nursing? ___Yes ___No Taking Birth Control? ___Yes ___No

Check if you have had any of the following:

__ Aids	__Cortisone Treatment	__Hepatitis	__Anemia	__Arthritis
__ Asthma	__Back Problems	__Blood Disease	__Cancer	__Chemotherapy
__ Circulatory Problems	__Cough, Persistent	__Artificial Joints	__Cough, Blood	__Diabetes
__ Drug Addiction	__Heart Murmur	__Glaucoma	__HIV	__Epilepsy
__ Fainting	__Headaches	__Hemophilia	__Heart Problems	__High Blood Pressure
__ Jay Pain	__Kidney Disease	__Liver Disease	__Never Problems	__Pacemaker
__ Psychiatric Care	__Radiation Treatment	__Respiratory Disease	__ Stroke	__Swelling
__ Thyroid Disease	__Tobacco Habit	__Tonsillitis	__Tuberculosis	__Ulcer
__ Venereal Disease	__Skin rash	__Sinusitis	__Mitral Valve Prolapse	

MEDICATIONS
List any medications you are taking:

_____

_____

ANY ALLERGIES
List any allergies or allergic Reactions:

_____

_____

Authorization

I, the undersigned, give my consent to dental treatment for myself (or my dependent) and assign all insurance benefits directly to Cuspids, Inc. and Dr. Louis A. Hassell. I understand that any amount paid at an appointment is estimated and any difference between that and actual insurance payment will be billed to me. Furthermore, I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all submissions to insurance. I also understand the information that I have given is correct to the best of my knowledge.

_____	_____	_____
Responsible party Signature	Relationship	Date

Dr. Louis A. Hassell
3796 Ashley Phosphate Road
North Charleston, SC 29418
(843) 767-3300

Today's Date:_____

General Patient Information

Patient Name:_____Social Security #:_____-_____-_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone: _____Cell Phone:_____

Gender:_____ Birthday:_____Age: _____ Marital Status: S M W D

Email:_____

Emergency Contact:_____Relationship:_____Phone:_____

How have you heard of our office? Please check all that apply O Friend Friends Name:_____

O Yellow Pages O Family Member O Newspaper O Internet O Previous Patient O Insurance Plan

O Staff Member O School O Direct Mail O Other: _____

IF PATIENT IS AN ADULT:

Employer:_____ Spouse:_____

Address:_____ Employer:_____

Position:_____ Address:_____

Phone Number:_____ Phone Number:_____

Social Security #:_____ Social Security #:_____

Drivers License #:_____ Drivers License #:_____

IF PATIENT IS A CHILD:

Father:_____ Mother:_____

Employer:_____ Employer:_____

Position:_____ Position:_____

Phone Number:_____ Phone Number:_____

Social Security #:_____ Social Security #:_____

Insurance Information

Primary Insurance	**Secondary Insurance**
Policy Holder:_____	Policy Holder:_____
Birthdate:_____Employer:_____	Birthdate:_____Employer:_____
Insurance Company:_____	Insurance Company:_____
Insurance Phone: _____	Insurance Phone: _____
Address: _____	Address: _____
Policy / Group #: _____	Policy / Group #: _____
Employee ID#: _____	Employee ID#: _____