dental excellence
of southbay

**New Patient Form**

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions upon arrival of your appointment we will be happy to help you. We will look forward to working with you in maintaining your dental health.*

## Patient Information

Date_____ Home phone( ) _____ Cell phone( ) _____Work phone( ) _____

Patient name_____ Social security# _____ Sex ___ M ___ F

Home address, City, State, Zip _____

E-Mail address _____ Birthdate _____ Age _____

Patient employer _____ Occupation_____

___Married ____ Widowed ____Single ____Minor ____Divorced _____Partnered

Employer address_____

Whom may we thank for referring you? _____

In case of emergency who should be notified _____Phone ( ) _____

## Primary Insurance

Person responsible for account _____

Relation to patient _____ Birth date _____ Social Security#_____

Address if different from patients _____

Responsible insured employer name _____ Occupation _____

Employer address _____ Employer phone ( ) _____

Insurance Company name _____ Ins. Co phone ( ) _____

Group # _____ Insured ID # on Ins. card _____

## Secondary Insurance

Person responsible for account _____

Relation to patient _____Birthdate _____Social security#_____

Address if different from patients _____

Responsible insured employer name _____ Occupation_____

Employer address _____Employer phone( )_____

Insurance Co Name _____ Ins. Co phone ( ) _____

Group # _____ Insured ID # on Ins. Card _____

## Dental History

Reason for today's Visit _____ Date of last dental care_____

Former dentist name_____ Date of last dental x-rays _____

Former dentist address and phone# _____

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

___ Bad breath ___Grinding teeth ___Sensitivity to hot ___Bleeding gums

___Loose teeth ___Broken teeth ___Sensitivity to sweets ___Clicking or popping jaws

___Sensitivity to cold ___Sensitivity to biting ___Sores in mouth ____Food collection between teeth

How often do you floss? _____ How often do you brush? _____

## Medical history

Physician's name _____ Date of last medical visit _____

Have you ever had a serious illness or operation, if so describe _____

Have you ever had a blood transfusion, if yes give dates _____

(Women) Are you pregnant ____Y ____ N If yes give due dates _____ Nursing __Y ___N

Check if you have had any of the following

| | | | |
|---|---|---|---|
| ___Anemia | ___Cortisone treatments | ____Hepatitis | ____Scarlet fever |
| ___Arthritis, Rheumatism | ___Persistent cough | ___High blood pressure | ___Shortness of breath |
| ___Artificial heart valves | ___Cough up blood | ___HIV/Aids | ___Skin Rashes |
| ___Artificial joints | ___Diabetes | ___Jaw pain | ___Stroke |
| ___Asthma | ___Epilepsy | ___Kidney disease | ___Swelling/feat/ankles |
| ___Back problems | ___Fainting | ___Liver disease | ___Thyroid problems |
| ___Blood disease | ___Glaucoma | ___Mitral valve prolapsed | ___Tobacco habits |
| ___Cancer | ___Frequent headaches | ___Pacemaker | ___Tonsillitis |
| ___Chemical dependency | ___Heart Murmur | ___ Radiation treatments | ___Tuberculosis |
| ___Chemotherapy | ___Heart problems | ___ Respiratory disease | ___Ulcers |
| ___Circulatory problems | ___Hemophilia | ___Rheumatic fever | ___Venereal disease |

Please list medications you are currently taking _____
_____

Please list any allergies you may have to medication or in general _____
_____

## Authorization for treatment

**I give my consent for me or my dependants dental treatment and care to Dr. Russell Coser. The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

_____ _____
**Signature Patient/Parent, Guardian, Personal Representative** **Date**

_____ _____
**Please print name of Patient/Parent, Guardian or P.R.** **Relationship to Patient**