



## Edward B. Coffey, DDS MS - Encinitas Dental Art

### welcome

Welcome to our practice! Our intention is to assist you in acquiring and maintaining your best oral health. This includes: 1) restoring your teeth so that they are comfortable, functional, and attractive 2) treating your gum tissue for a lifetime of periodontal health, and 3) evaluating your general health and habits to ensure a life-long future of overall excellent oral health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments you may have. The more we know about your needs and concerns, the better we can serve you. Thank you!

### patient information

NAME George Nasif NICKNAME Georgie DRIVER'S LICENSE E0647889  
FIRST NAME LAST NAME  
ADDRESS PO Box 2282 CITY Del Mar ZIP 92014  
SOCIAL SECURITY # 545-90-4041 SEX: M ☒ F AGE 63 BIRTH DATE 06/16/1954  
EMPLOYED BY Retired OCCUPATION IT InterneSecurity HOW LONG 10 Years  
HOME PHONE ( 858 ) 900-6807 BUSINESS PHONE ( 858 ) 900-6807  
CELL PHONE ( 858 ) 900-6807 E-MAIL ADDRESS g.nasif@yahoo.com  
STUDENT (full time) ☐ YES ☒ NO COLLEGE Coleman University  
SPOUSE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_  
PHONE & NAME OF FRIEND OR RELATIVE TO  
CONTACT IN CASE OF EMERGENCY \_\_\_\_\_

### responsible party information (if different from above) In the event of any dispute between Dr. Coffey and patient, the prevailing party shall recover reasonable attorney's fees.

NAME Same as above DRIVER'S LICENSE # \_\_\_\_\_  
FIRST NAME LAST NAME  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ SEX: M / F AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_ HOW LONG \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ BUSINESS PHONE ( \_\_\_\_\_ ) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

### insurance information The following is for insured only

DO YOU OR RESPONSIBLE PARTY HAVE DENTAL INSURANCE? ☒ YES ☐ NO  
INSURANCE CO CHG or Medi Cal self insured PHONE# ( \_\_\_\_\_ ) GROUP # \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
FIRST NAME LAST NAME  
SOCIAL SECURITY # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

As a courtesy, it is our wish to assist in the preparation and completion of your dental insurance claims. In order to do this accurately, the above information MUST be provided by you. Due to the volume of insurance policies, it is IMPOSSIBLE for us to provide you an EXACT estimated out-of-pocket figure. You are responsible in FULL for whatever is not covered by your insurance company.

### how did you hear about us?

WHOM MAY WE THANK FOR REFERRING YOU? ☐ Our Website ☐ Yelp ☐ Drive-by ☒ Patient self  
☐ Internet (specify website) \_\_\_\_\_ ☐ Coupon (specify) \_\_\_\_\_  
☐ Other (specify) Past client 10 years ago

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### medical information

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General health: ☐excellent ☐good ☐fair ☒poor

Name and phone number of your physician:

Dr. Michael MacMurray 7606335000

How long has it been since your last complete physical examination?

2006/07

Are you presently taking any blood thinners?

(i.e. Coumadin, Aspirin):

☒YES ☐NO

Are you taking any medications or drugs?

(please list)

☒YES ☐NO

Are you allergic to any medications?

(please list)

☐YES ☒NO

Are you taking any Bisphosphonate drugs?

(i.e. Fosamax, Boniva, etc.)

☐YES ☒NO

Do you need to be pre-medicated?

(Take antibiotics before seeing a dentist for artificial joints or heart conditions?)

☐YES ☒NO

Have you ever had a serious illness that required hospitalization?

yes, several surgeries and heart attacks

What and when?

2008- 2015

Have you ever had abnormal bleeding after any surgical procedure?

no

Please check any of the following that you have ever had or been treated for:

- ☒ diabetes
- ☐ rheumatic fever
- ☒ heart murmur
- ☐ heart disorder
- ☒ heart attack
- ☐ mitral valve prolapse
- ☐ stroke
- ☒ high blood pressure
- ☐ swelling in ankles
- ☒ difficulty in breathing
- ☐ rapid weight gain or loss
- ☐ thyroid disease or malfunction
- ☐ kidney disease or malfunction
- ☐ joint replacement
- ☐ epilepsy
- ☒ frequent headaches or earaches
- ☐ tuberculosis
- ☐ glaucoma
- ☒ asthma or hay fever
- ☐ hepatitis
- ☐ anemia
- ☐ cancer
- ☐ venereal disease
- ☐ (Women: are you pregnant?)
- ☐ AIDS or AIDS Related Complex (ARC)
- ☐ former alcoholic
- ☐ former drug addict

**Comments:** under control with diet/med

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### dental information

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Are you in dental discomfort today?

yes, 2 crowns fell out

What would you like us to do to make you more comfortable or relaxed during your dental visit?

reset crowns

Have you ever had orthodontic treatment? (braces)

No

Have you ever had an unpleasant dental experience in the past?

No

How do you feel about the appearance of your teeth?

could be better

Do your gums bleed when you floss or brush?

a little

Have you been treated by a periodontist? (Gum specialist)

no

How long has it been since your last dental treatment?

1/2008

Is there anything else you would like us to know about your dental health or your previous dental treatment?

Need cleaning,x rays,Crowns done

### Cancellation Policy

We request the courtesy of a MINIMUM **24 hour** notice in the event an appointment needs to be cancelled or rescheduled. If you do not cancel your appointment within **24 hours** or if you miss an appointment, a \$50.00 per hour no show fee will apply.

*I authorize and give consent to perform dental services agreed between doctor and patient to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I acknowledge receipt of information regarding my rights under HIPAA law.*

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Patient Signature

If minor - Parent or Guardian

Date