S. Kafayi D.D.S.

450 Sutter St. Suite 2104, San Francisco, CA 94108

PATIENT REGISTRATION AND HEALTH HISTORY

(Please complete the following confidential information)

PATIENT INFORMATION

Today's date_____

Patient's Name:_____

☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

Patient's Birthdate:_____

Spouse's Name:_____

Parent's Name (if child):_____

Patient's Street Address:_____

City_____ State_____ Zip_____

Telephone: Home_____

Business _____ Cell _____

E-mail _____

Patient's Employer:_____

Present Position:_____ How long_____

Spouse's Employer:_____

Present Position:_____ How long_____

Who Referred You?_____

Who Will Pay This Acct?_____

Purpose of Call:_____

Your Social Security No._____

Your Driver's License No._____

Spouse's Social Security No._____

School's Name (if student)_____

Billing Address:_____

DENTAL INSURANCE INFORMATION

Primary Carrier

Employee Name:_____

Soc. Sec. No._____ Birthdate:_____

Street Address:_____

City_____ State_____ Zip_____

Employer Company Name:_____

Street Address:_____

City_____ State_____ Zip_____

Insurance Co. Name:_____

Ins. Co. Address:_____

City_____ State_____ Zip_____

Ins. Co. Phone No. _____

Group or Plan No. _____

Secondary Carrier

Employee Name:_____

Soc. Sec. No._____ Birthdate:_____

Street Address:_____

City_____ State_____ Zip_____

Employer Company Name:_____

Street Address:_____

City_____ State_____ Zip_____

Insurance Co. Name:_____

Ins. Co. Address:_____

City_____ State_____ Zip_____

Ins. Co. Phone No. _____

Group or Plan No. _____

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies.

The undersigned patient also authorizes the release of such information to any peer review committee or state and local dental association which may request it.

Patient/Responsible Party Signature:_____ Date:_____

OVER, PLEASE

Previous Dentist's Name_____ Telephone_____

Address_____

Current Physician's Name_____ Telephone_____

Address_____

1. Are you having pain or discomfort at this time?.....YES NO
2. Have you been a patient in the hospital during the past two years.....YES NO
3. Have you taken any medication or drugs during the past two years.....YES NO
4. Are you now taking any medication, including any Bisphosphonate for Osteoporosis (Fosomax, Boniva, Zometa, ect.).....YES NO

   If yes, please list: _____

5. Do you wear contact lenses.....YES NO
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? (Latex?).....YES NO

   If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure.....YES NO	Stroke.....YES NO	Hepatitis A (infectious).....YES NO
Heart Disease or Attack.....YES NO	Artificial Joints (hip, knee, etc.)....YES NO	Hepatitis B (serum).....YES NO
Angina Pectoris.....YES NO	Kidney Trouble.....YES NO	Venereal Disease.....YES NO
Congenital Heart Disease....YES NO	Ulcers.....YES NO	A.I.D.S.....YES NO
Heart Murmur.....YES NO	Diabetes.....YES NO	H.I.V. Positive.....YES NO
High Blood Pressure.....YES NO	Thyroid Problems.....YES NO	Cold Sores/Fever Blisters.....YES NO
Arteriosclerosis.....YES NO	Glaucoma.....YES NO	Blood Transfusion.....YES NO
Mitral Valve Prolapse.....YES NO	Cosmetic Surgery.....YES NO	Hemophilia.....YES NO
Artificial Heart Valve.....YES NO	Emphysema.....YES NO	Anemia.....YES NO
Heart Pacemaker.....YES NO	Chronic Cough.....YES NO	Sickle Cell Disease.....YES NO
Heart Surgery.....YES NO	Tuberculosis.....YES NO	Bruise Easily.....YES NO
Rheumatic Fever.....YES NO	Asthma.....YES NO	Liver Disease.....YES NO
Arthritis.....YES NO	Hay Fever.....YES NO	Yellow Jaundice.....YES NO
Rheumatism.....YES NO	Allergies or Hives.....YES NO	Epilepsy or Seizures.....YES NO
Pain in Jaw Joints.....YES NO	Sinus Trouble.....YES NO	Fainting or Dizzy Spells.....YES NO
Cortisone Medicine.....YES NO	Radiation Therapy.....YES NO	Nervousness.....YES NO
Drug Addiction.....YES NO	Chemotherapy.....YES NO	Psychiatric Treatment.....YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired.....YES NO
9. Do your ankles swell during the day.....YES NO
10. Do you use more than two pillows to sleep.....YES NO
11. Have you lost or gained more than 10 pounds in the past year.....YES NO
12. Do you ever wake up from, sleep and feel short of breath.....YES NO
13. Are you on a special diet.....YES NO
14. Has your medical doctor ever said you have a cancer or tumor.....YES NO
15. Do you have or have you had any disease, condition, or problem not listed.....YES NO

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) may be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____

Parent or Responsible Party_____ Relationship to Patient _____