SASSAN 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 Employer: ______________________

Patient's Name:______________________ Present Position: ____________ How long________

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced Spouse's Employer:______________________

Patient's Birthdate: ______________________ Present Position:____________ How long________

Spouse's Name:______________________ Who Referred You?______________________

Parent's Name (if child):______________________ Who Will Pay This Acct?______________________

Patient's Street Address:______________________ Purpose of Call:______________________

City______________ State________ Zip________ Your Social Security No.______________________

Telephone: Home______________________ Your Driver's License No.______________________

Business______________________ Spouse's Social Security No.______________________

Cell______________________ School's Name (if student)______________________

Billing Address:____

DENTAL INSURANCE INFORMATION

Primary Carrier	Secondary Carrier
Employee Name:______________________	Employee Name:______________________
Soc. Sec. No.____________ Birthdate:____________	Soc. Sec. No.____________ Birthdate:____________
Street Address:______________________	Street Address:______________________
City______________ State________ Zip________	City______________ State________ Zip________
Employer Company Name:______________________	Employer Company Name:______________________
Street Address:______________________	Street Address:______________________
City______________ State________ Zip________	City______________ State________ Zip________
Insurance Co. Name: ______________________	Insurance Co. Name: ______________________
Ins. Co. Address:______________________	Ins. Co. Address:______________________
City______________ State________ Zip________	City______________ State________ Zip________
Ins. Co. Phone No. ______________________	Ins. Co. Phone No. ______________________
Group or Plan 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, drugs or pills .... 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

---

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 __________