



CENTER FOR  
COSMETIC AND SEDATION DENTISTRY

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# PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE BOTH SIDES OF THE FOLLOWING CONFIDENTIAL INFORMATION

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS  
OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Name I like to be called \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ E-Mail \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's or Parent's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's or Parent's Occupation \_\_\_\_\_ Spouse's or Parent's Employer \_\_\_\_\_

Contact Phone Number (\_\_\_\_) \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Check if same as above; proceed to next section

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

## DENTAL INSURANCE

Employee Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Company Phone (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Group # \_\_\_\_\_

## GETTING TO KNOW YOU

Please list the members of your family that are patients in our office: Names: \_\_\_\_\_

How did you hear about our office?  Yellow Pages  Website  Friend (Name) \_\_\_\_\_

Newspaper  Sign  TV  Magazine  Other \_\_\_\_\_

Person to contact in case of emergency (not living with you):

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? YES NO  
Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_
2. Are you now taking any medication, drugs or pills? YES NO  
If yes, please list: \_\_\_\_\_
3. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO  
If yes, please list: \_\_\_\_\_
4. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.
- |                                |        |   |        |                                 |        |
|--------------------------------|--------|---|--------|---------------------------------|--------|
| Heart Failure .....            | YES NO | Artificial Joints (hip, knee, etc.) ... | YES NO | Hepatitis B (serum) .....       | YES NO |
| Heart Disease or Attack .....  | YES NO | Kidney Trouble .....                    | YES NO | Fibromyalgia .....              | YES NO |
| Angina Pectoris .....          | YES NO | Ulcers .....                            | YES NO | A.I.D.S. ....                   | YES NO |
| Congenital Heart Disease ..... | YES NO | Diabetes .....                          | YES NO | H.I.V. Positive .....           | YES NO |
| Heart Murmur .....             | YES NO | Thyroid Problems .....                  | YES NO | Cold Sores/Fever Blisters ..... | YES NO |
| High Blood Pressure .....      | YES NO | Glaucoma .....                          | YES NO | Blood Transfusion .....         | YES NO |
| Arteriosclerosis .....         | YES NO | Cosmetic Surgery .....                  | YES NO | Hemophilia .....                | YES NO |
| Mitral Valve Prolapse .....    | YES NO | Emphysema .....                         | YES NO | Anemia .....                    | YES NO |
| Artificial Heart Valve .....   | YES NO | Chronic Cough .....                     | YES NO | Sickle Cell Disease .....       | YES NO |
| Heart Pacemaker .....          | YES NO | Tuberculosis .....                      | YES NO | Bruise Easily .....             | YES NO |
| Heart Surgery .....            | YES NO | Asthma .....                            | YES NO | Liver Disease .....             | YES NO |
| Rheumatic Fever .....          | YES NO | Hay Fever .....                         | YES NO | Yellow Jaundice.....            | YES NO |
| Arthritis .....                | YES NO | Allergies or Hives .....                | YES NO | Epilepsy or Seizures.....       | YES NO |
| Rheumatism .....               | 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 |
| Stroke .....                   | YES NO | Hepatitis (infectious).....             | YES NO | Developmentally Disabled .....  | YES NO |
5. Do you use tobacco in any form? YES NO  Cigarettes \_\_\_\_ packs a day /  Chewing tobacco....How much? \_\_\_\_\_
6. Do you have or have you had any disease, condition, or problem not listed?  
If yes, please list: \_\_\_\_\_
7. **FOR WOMEN ONLY:**  
Are you taking birth control pills?  No  Yes Are you pregnant?  No  Yes, what month? \_\_\_\_\_ Are you nursing?  No  Yes

## DENTAL HISTORY

1. Are you having pain or discomfort at this time? YES NO  
If yes, Describe problem: \_\_\_\_\_
2. When was your last dental visit? \_\_\_\_\_ For what? \_\_\_\_\_
3. Have you ever had an upsetting dental experience? YES NO  
If yes, explain \_\_\_\_\_
4. Please rate your dental level of anxiety: High Average Low None  
Explain \_\_\_\_\_
5. Is there anything else that bothers you about coming to the dentist? YES NO  
If yes, explain \_\_\_\_\_
6. Are you happy with the appearance of your teeth when you smile? YES NO  
If no, what would you like to change? \_\_\_\_\_

## CONSENT:

- The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- I understand that I am responsible for payment for all dental services provided in this office for myself or my dependents. I will be responsible for the deductible and the ESTIMATED Co-payment on the appointment day. I know I am responsible for ANY balance not covered by my insurance. A 1.5% finance charge (18% APR) will be added to accounts over 30 days. Should collections become necessary, I will be responsible for ALL collection cost, including attorney and court fees.

Patient (or parent) signature \_\_\_\_\_

Date \_\_\_\_\_