Parisa Shahi DDS FACP **REGISTRATION**

Patient	Name:		Female ☐ Male ☐
	Address:		Home Phone
	City: State: ZIP:		Cell Phone:
	E-Mail Address:		Work Phone
	Birthdate	Social Security Number	Driver's Lic. No.
	Occupation:		
Student?	Full-time Student ☐ Yes ☐ No	Name and Address of School	
Married?	☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed		Spouse's Name:
	Birthdate	Social Security Number	Work Phone
Responsible Party (If Not Patient)	Name:		Female ☐ Male ☐
	Address:		Home Phone
	City: State: ZIP:		Work Phone
	Birthdate	Social Security Number	
Married?	☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed		Spouse's Name:
	Birthdate	Social Security Number	Work Phone

I request professional services from Dr. Schauer. I agree that any balance on my account that becomes 30 days past due, will be subject to a 1% service charge or the highest rate permitted by law, whichever is less, and to pay all costs of collection including reasonable attorney's fees.

Signature:_____ Date:_____

Employer and Health Insurance Information	Name of Employee	Group Insurance Name/Group Number
	Employer	Insurance Carrier
	Address	Carrier Address
	City, State, Zip	City, State, Zip
Other Employer and Health Insurance Information	Name of Employee	Group Insurance Name/Group Number
	Employer	Insurance Carrier
	Address	Carrier Address
	City, State, Zip	City, State, Zip
Referral	Referred by:	Phone:
	Address	City, State, Zip

Patient: _____ Date: _____

MEDICAL HISTORY

Who should we contact in case of emergency: _____ Phone number: _____
Physician's Name and Address: _____
Physician's Phone Number: ( ) _____ Date of last examination: _____
How would you describe your general health? [ ] Good [ ] Fair [ ] Poor
Are you on a special diet or have dietary restrictions? [ ] Yes [ ] No
Please explain: _____

Please circle the appropriate response for each of the following:

NH = Never Had PC = Previous Condition CC = Current Condition

Heart Disease	NH	PC	CC	Asthma	NH	PC	CC	Thyroid Disorder	NH	PC	CC
Heart Murmur	NH	PC	CC	Ulcers	NH	PC	CC	Diabetes	NH	PC	CC
Artificial Implants (hip joints, pacemakers, breast implants, etc.)	NH	PC	CC	X-ray, Radium or Cobalt Treatment	NH	PC	CC	Other Gland Disorders	NH	PC	CC
High Blood Pressure	NH	PC	CC	Tumors or Malignancies	NH	PC	CC	Hepatitis	NH	PC	CC
Stroke	NH	PC	CC	Psychiatric Problems	NH	PC	CC	Other Liver Disease	NH	PC	CC
Muscle Disorders	NH	PC	CC	HIV Infection	NH	PC	CC	Arthritis	NH	PC	CC
Nerve Disorders	NH	PC	CC	Venereal Disease	NH	PC	CC	Osteoporosis see note*	NH	PC	CC
Epilepsy	NH	PC	CC	Ear Trouble	NH	PC	CC	Urinary Disorders	NH	PC	CC
Blood Clotting Disorders	NH	PC	CC	Hay Fever	NH	PC	CC	Kidney Disorders	NH	PC	CC
Anemia	NH	PC	CC	Skin Disease	NH	PC	CC	Other _____	NH	PC	CC
Emphysema	NH	PC	CC	Eye Disease	NH	PC	CC	_____			

Is there anything else about your health I should know?: _____
_____
If you are currently undergoing any kind of Medical/Dental treatment, please fill out the following information:
1. Condition being treated: _____
2. Condition being treated: _____

Please check if you are sensitive or allergic to any of the following:
[ ] **Penicillin** [ ] **Dental anesthetics** [ ] **Barbiturates** [ ]**Codeine** [ ] **Other**

Please list all prescription and over-the-counter medications, drugs, pills, capsules, etc. you are now taking or have taken within the past year:

Medicine	Amount Taken	How Often?

Please check the appropriate box below and indicate the amount used for each of the following:

NU = Never Used PU = Previously Used CU = Currently Using

				Amount				Amount
Caffeine containing drinks (coffee, tea, etc.)	NU	PU	CU	_____	Narcotics (heroine, demerol, percodan, etc.)	NU	PU	CU	_____
Tobacco	NU	PU	CU	_____	Cocaine, Crack, etc.	NU	PU	CU	_____
Alcoholic Beverages	NU	PU	CU	_____	PCP, Angel Dust, etc.	NU	PU	CU	_____
Amphetamines (uppers, speed, crank, etc.)	NU	PU	CU	_____					

Have you ever been treated for abuse of the above substances? [ ] Yes [ ] No
If yes, please describe: _____

For Women Only:
Are you pregnant? [ ] Yes [ ] No
Do you take **birth control pills**? [ ] Yes [ ] No
Are you in or have you passed through menopause? [ ] Yes [ ] No
*Are you taking or have you taken antiresorbtive medication? [ ] Yes [ ] No, If yes which one and how long? _____

Signature: _____ Date: _____