Dr. Danish
facial plastic surgery

REGISTRATION FORM

DATE: _____ REFERRED BY _____

THE FOLLOWING INFORMATION WILL HELP US TO SERVE YOU BETTER. YOUR RESPONSES ARE HELD STRICTLY CONFIDENTIAL.

PLEASE PRINT CLEARLY.

NAME _____

ADDRESS _____CITY _____STATE _____ ZIP_____

DATE OF BIRTH _____ AGE _____ CELL PHONE ( ) _____

WORK PHONE: ( ) _____ HOME PHONE ( ) _____

E-MAIL ADDRESS _____

EMPLOYER _____

NAME OF SPOUSE _____

EMPLOYER _____ WORK PHONE ( )_____

IF MINOR:

FATHER'S NAME _____ BIRTH DATE _____

EMPLOYER _____ WORK # _____

MOTHER'S NAME: _____ BIRTH DATE _____

EMPLOYER _____ WORK # _____

PLEASE CONTINUE.....

HEALTH HISTORY QUESTIONNAIRE

PATIENT: _____ DATE _____ AGE _____ GENDER _____

What medications are you **now** taking?

_____

_

Are you **allergic** or have you reacted adversely to any of the following medications (If yes, please check):

Penicillin ☐ Tetracycline ☐ Erythromycin ☐ Other antibiotic ☐

Aspirin ☐ Codeine ☐ Local anesthetic (Novocain or Lidocaine) ☐

Are you allergic to **latex**? ◯ Yes ◯ No

Are you allergic to any other medication or substance? ◯ Yes ◯ No

If yes, please list:

_____

PAST SURGICAL HISTORY (please list)

_____

_____

Please check any of the following which you have had or have now:

☐ Heart Failure	☐ Heart Murmur	☐ Stroke	☐ Hepatitis or Liver Disease
☐ Heart Disease or Attack	☐ Diabetes	☐ Blood Transfusion	☐ Angina Pectoris
☐ Anemia	☐ Kidney Disease	☐ Bruise Easily	☐ Sickle Cell Disease
☐ High Blood Pressure	☐ Ulcers	☐ Thyroid Disease	☐ Scarlet Fever
☐ Emphysema	☐ Arthritis	☐ Drug Addiction	☐ Hemophilia
☐ Mitral Valve Prolapse	☐ Cough	☐ Rheumatism	☐ Rheumatic Fever
☐ TB	☐ Cold Sores	☐ Fever Blisters	☐ Cortisone Medicine
☐ Congenital Heart Lesions	☐ Asthma	☐ Glaucoma	☐ Epilepsy or Seizures
☐ Artificial Heart Valve	☐ Hay Fever	☐ Sinus Problems	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Allergies or Hives	☐ A.I.D.S./HIV	☐ Chemotherapy (Cancer, Leukemia)
☐ Heart Surgery	☐ Venereal Disease	☐ Treatment with X-ray, Radiation, or Cobalt	

I certify that the above information is true.

_____ Date _____

Patient Signature

MYRA N. DANISH, MD, FACS
4550 INVESTMENT DRIVE STE#290
TROY, MI 48098
248-267-9700

ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the **Notice of Privacy Practices** **Date** _____

_____ _____
Patient Name (please print) Patient Date of Birth

_____
Patient Signature

_____ _____
Name of Parent/Guardian Relationship to Patient

_____
Signature of Parent/Guardian

☐ The practice is now using SMS Text and Email to confirm appointments and send communications. Please check this box if you would like to opt out of text and email communications.

Please list name of person(s) that you would allow our office to give information to regarding your medical condition.

1._____ _____
Relationship

2._____ _____
Relationship

Please notify our office in writing with any changes to the above list.

Please see a member of our staff with any questions that you may have regarding our **Notice of Privacy Practices.**