SONA KHINVASARA, DDS, Inc.

REGISTRATION AND HEALTH HISTORY

Date:

Name ______ Birthdate ______ Home Phone ______ E-mail ______

Residence Address ______ City ______ State ______ Zip ______

Employed By ______ Position ______ Soc. Sec. No. ______

How Long Held ______ Business Telephone ______ Dental Insurance Co. ______

Group Number ______ Insurance Telephone ______ Union Local ______ Cell Phone ______

Name of Spouse ______ Birthdate ______ SS# ______

Spouse Employed By ______ How Long ______ Telephone ______

Position Held ______ Spouse's Dental Insurance Co. ______ Group Number ______

Union Local ______ Who Will Pay For This Account ______

Who May We Thank For Your Referral ______

Your Medical History

Your Primary Physician's Name ______ Telephone ______

Do you have or have you had any of the following? Please indicate with check mark.

- ☐Heart problems
- ☐High blood pressure
- ☐Low blood pressure
- ☐Circulatory problems
- ☐Radiation treatments
- ☐Excessive bleeding
- ☐Allergies to medications
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Diabetes
- ☐Hepatitis
- ☐HIV positive
- ☐Neurological disorders
- ☐Malignancies
- ☐Measles
- ☐Mumps
- ☐Psychiatric care
- ☐Rheumatic fever
- ☐Sinus problems
- ☐Stroke
- ☐Tuberculosis
- ☐Ulcer
- ☐Venereal disease

Please list any surgeries about the head or neck ______

Describe current, ongoing medical treatment ______

Please list any heart surgeries or precautions ______

List any upcoming medical surgeries or treatment ______

Please fill out all information requested on this page