Dr. Danish
facial plastic surgery

WELCOME TO Dr. Danish Plastic Surgery & Spa!

Please check any of the following service(s) you would like to learn more about:

- ☐ **New!!!** Lumenis Light Sheer Duet Laser.
  - *Permanent Hair Reduction*
  - *Pain Free and Fast*
  - *Good for All Skin Types*
  - *Reduces in-grown hairs*

- ☐ **MicroNeedling**
  - *Improve and repair fine lines*
  - *Sun damaged skin*
  - *Mild acne and scars*
  - *Pores*

- ☐ **Genesis Laser and Excel V Laser Facial Treatments**
  - *Improve and repair fine lines*
  - *Sun damaged skin*
  - *Mild acne and scars*
  - *Pores*
  - *Rosacea*
  - *Pigmentation*

- ☐ **Body and Face Tightening and Contouring Viora Reaction**

- ☐ Laser Spider Vein Removal for both Legs and Face

- ☐ **Skin Care Products and Glycolic Peels / Microdermabrasion**
  - *Anti-Aging*
  - *Acne*
  - *Uneven Pigmentation*
  - *Reducing Facial Redness*

- ☐ Customized Skin Care Programs and Training, including Dermablend

- ☐ Hair Salon

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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.**