REGISTRATION

(PLEASE PRINT)

Comprehensive Cardiovascular, P.C.
Joseph L. Musso, M.D., F.A.C.C.
9407 156th Avenue, Suite 200
Howard Beach, New York 11414

Telephone: (718) 323-3773
Fax: (718) 323-3777

Date ______________________ Home Phone (_____) ______________________ Cell Phone (_____) ______________________

PATIENT INFORMATION

Name ______________________ SS/HIC/Patient ID # ______________________
Last Name First Name Middle Initial

Address ______________________ E-mail ______________________

City ______________________ State ________ Zip ______________________

Sex ☐ M ☐ F Age ______ Birthdate ______________________ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______________________ Occupation ______________________

Employer/School Address ______________________ Employer/School Phone (_____) ______________________

Whom may we thank for referring you? ______________________

In case of emergency who should be notified? ______________________ Phone (_____) ______________________

PRIMARY INSURANCE

Person Responsible for Account ______________________
Last Name First Name Middle Initial

Relation to Patient ______________________ Birthdate ______________________ Soc. Sec. # ______________________

Address (If different from patient's) ______________________ Phone (_____) ______________________

City ______________________ State ________ Zip ______________________

Person Responsible Employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone (_____) ______________________

Insurance Company ______________________

Contract # ______________________ Group # ______________________ Subscriber # ______________________

Names of other dependents covered under this plan ______________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________ Birthdate ______________________ Relation to Patient ______________________

Address (If different from patient's) ______________________ Phone (_____) ______________________

City ______________________ State ________ Zip ______________________

Subscriber Employed by ______________________ Business Phone (_____) ______________________

Insurance Company ______________________ Soc. Sec. # ______________________

Contract # ______________________ Group # ______________________ Subscriber # ______________________

Names of other dependents covered under this plan ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)
Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

#10505 – © 2004 Medical Arts Press™ 1-800-328-2179

CONFIDENTIAL

MEDICAL HISTORY

Date ______________ SS/HIC/Patient ID# ________________________

Patient Name ____ Date of Birth ____________

Check (✓) if you have or have had problems with any of the following:

Condition	Yes	No
AIDS/HIV Positive	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma or Hay Fever	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer Therapy	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Measles or mumps	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nasal Obstruction	☐ Yes	☐ No
Neurological Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

Medication	Presently Taking	Taken in the Past	History of Reaction
Anesthetics, Locally Injected	☐	☐	☐
Anesthetics, General	☐	☐	☐
Antacids	☐	☐	☐
Anti-anxiety Medications	☐	☐	☐
Anti-depressants	☐	☐	☐
Antihistamines	☐	☐	☐
Daily Aspirin Regimen	☐	☐	☐
Birth Control Pills	☐	☐	☐
Blood Pressure Medications	☐	☐	☐
Codeine, Demerol or Other Analgesics	☐	☐	☐
Cortisone or Other Steroids	☐	☐	☐
Coumadin, Heparin, Warfarin or other blood thinners	☐	☐	☐
Dilantin	☐	☐	☐
Diuretics (water pills)	☐	☐	☐
Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)	☐	☐	☐
Heart Medications such as Digoxin, Nitroglycerin or Digitalis	☐	☐	☐
Ibuprofen (Motrin)	☐	☐	☐
Insulin or Diabetes Medications	☐	☐	☐
Sedatives or Tranquilizers	☐	☐	☐
Sleeping Pills (Barbiturates)	☐	☐	☐
Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine	☐	☐	☐
Tylenol (Acetomeniphen)	☐	☐	☐

Adverse reaction to any other medication or drug ☐ Yes ☐ No

Please specify ____________________

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor

Pharmacy Name ______________________________ Phone ( ) ______________

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Have you had any serious illnesses or surgeries? ☐ Yes ☐ No If yes, describe ______________________________

Check (✓) your current use of:

	Yes	No
Tobacco	☐ Yes	☐ No
Packs per day ______		
Alcohol, Beer, Wine	☐ Yes	☐ No
Drinks per day ______		
Street Drugs	☐ Yes	☐ No
Times per day ______		
Caffeine	☐ Yes	☐ No
Cups per day ______		
High Stress	☐ Yes	☐ No
Reason ______		

Do you have any other health needs you should bring to our attention? ______________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ ____________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ____________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

#10005 @2005 Medical Arts Press® 1-800-328-2179