PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ Home Phone & Cell Phone _____

Patient _____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

Street Address _____ City _____ State _____ Zip _____

Sex: M __ F __ Age __ Birthdate _____ __ Single __ Married __ Widowed __ Separated __ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse's Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is Responsible for Account? _____

Relationship to patient? _____

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group # _____

In Case of Emergency, Who Should be Notified? _____

Phone # _____

Who may We Thank for Referring You? _____

Medical History

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check lines that apply) :

___ HEART PROBLEMS
___ HIGH BLOOD PRESSURE
___ LOW BLOOD PRESSURE
___ ARTIFICIAL HEART VALVE
___ HEART MURMUR
___ MITRAL VALVE PROLAPSE
___ RHEUMATIC HEART DISEASE
___ STROKE
_ ARTIFICIAL JOINTS
___ ORTHOPEDIC HARDWARE
___ BACK PROBLEMS
___ CHEMICAL DEPENDENCY
___ EPILEPSY
___ HEADACHES
___ HEPATITIS, JAUNDICE OR LIVER DISEASE
___ CANCER
___ ALLERGIES TO ANY DRUG
___ VENERAL DISEASE
___ RESPIRATORY DISEASE
___ GENERAL ALLERGIES
___ BLOOD DISEASE
___ HIV VIRUS OR OTHER IMMUNOSUPPRESSIVE DISORDERS
_ TUBERCULOSIS
___ SPECIAL DIET
___ SWOLLEN NECK GLANDS
___ RHEUMATIC FEVER
___ SINUS PROBLEMS
___ PSYCHIATRIC CARE
___ ULCER
___ ARTHRITIS
___ DIABETES
___ HEMOPHILIA
___ STROKE
_ OTHER

CONTINUED ON NEXT PAGE

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what?

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medications at this time? _____ If so, what? _____

Are you under the care of a physician? _____ Yes _____ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(women) Do you suspect that you are pregnant? _____ Are you nursing? _____

Are you taking Birth Control? ____ Yes ____ No _____

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE SIGNATURE AND E-MAIL ADDRESS

CONTINUED ON NEXT PAGE

Dr. Rolando Cibischino, D.M.D., M.A.G.D.

71 Summit Avenue
Hackensack, NJ 07601

Phone (201) 342-7742
Fax (201) 342-4647

Payment Policy

Payment for procedures is the patient's responsibility and is due at the time of visit.

In regards to patients that have valid dental insurance; as a courtesy to our patients, we will process and submit your insurance claim. It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
If insurance payments are sent to you, you are responsible for forwarding them to our office in a timely manner with a copy of the explanation of Benefits (EOB) received.

If there are any questions about payment, please ask us.

Collection Accounts

In the case your account is forwarded to a collections agency, you are responsible to pay reasonable attorney fees if applicable.

Cancellation Policy

Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office will result in a $50.00 fee. This fee is not reimbursable by your insurance company.

_____
Print your name here and sign below

x_____

Date: _____

Rolando Cibischino, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I_____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

- Individual refused to sign
- Communications barriers prohibited us from obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____