

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired  
Student Status:  Full Time  Part Time  
Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Do you use controlled substances?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Sulfa Drugs, Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Osteoporosis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above? If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X \_\_\_\_\_

Date: \_\_\_\_\_

DR. EUGENE ISOLA - 2 HOSPITAL PLAZA, SUITE 410, OLD BRIDGE, NJ 08857  
732-360-2500

Email: [drisola@smilesfoldbridge.com](mailto:drisola@smilesfoldbridge.com)  
Website: [www.smilesfoldbridge.com](http://www.smilesfoldbridge.com)

## TREATMENT AND FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you our staff will help you process all your insurance claims. Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. For your convenience, we do accept checks, cash as well as MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

All procedures involving lab work will require a 50% down payment, the remaining balance will be due as treatment progresses. The balance must be paid before final insertion.

Checks returned from the bank are subject to a \$35.00 service fee. Accounts delinquent more than 45 days from the date of billing are subject to a 1.5% per month finance charge.

We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I HAVE READ AND AGREE TO THE ABOVE FINANCIAL POLICY

\_\_\_\_\_ Print Name of Patient or Responsible Party

\_\_\_\_\_ Signature Date

**Dr. Eugene Isola III**  
**2 Hospital Plaza, Suite 410**  
**Old Bridge, NJ 08857**  
**P: (732) 360-2500**  
**F: (732) 360-0068**

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**OFFICE POLICY**

- I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referrals and covered services by my insurance company.
- I understand that Dr. Isola will bill my insurance carrier directly; however, I am responsible for full payment of demand. Should I receive any payments directly from carrier for services provided by Dr. Isola, I agree to forward the payments to the practice.
- I agree to pay any co-payments and/or deductibles as per my insurance plan.
- **I know that the ultimate responsibility for payment of service is mine.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of this office's notice of Privacy Practices.

**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 obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the signature
- An emergency situation prevented obtaining the signature
- Other, please specify: \_\_\_\_\_

**Signature by staff:** \_\_\_\_\_

**REQUEST OF PAYMENT OF BENEFITS TO PROVIDER OF CARE**

I hereby authorize and direct my insurance company to pay by check, and for it to be mailed directly to this office the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by the office. I certify that the information I have reported with regard to my insurance coverage is correct. I agree to be financially responsible for all the charges insured at this office, including my insurance deductible, co-payments, and any services rejected or not covered by my insurance company.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CONSENT TO TREAT**

I authorize Dr. Isola to examine, perform diagnostic procedures to prescribe or provide treatment for me as may be medically necessary. I understand that I will have the opportunity to obtain an explanation of any diagnosis that may be found, in terms that I understand from Dr. Isola. I also understand that I have the right to an explanation of benefits, risks, and expected results of any recommended treatment, and to be advised of all reasonable treatment options, including no treatment, and to an explanation of the risks and benefits that are involved with each alternative. I understand that if I do not comply with the recommendations of Dr. Isola, such failure may result in an adverse outcome.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FINANCIAL AGREEMENT**

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.
- As a courtesy to you, our staff will help you process all of your insurance claims. Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. For your convenience, we do accept checks, cash, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.
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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_