Faisal B. Isaacs, DMD., P.
603 West Nash Street Suite 3
Wilson, North Carolina 27893
252-291-6313

Patient Name: _____ **Date:** _____ **Date of Birth:** _____ *Please Circle One* **Male Female**
Last First MI

Social Security Number: _____ Single Married Separated Divorced Widowed Minor
Please Circle One

Street Address: _____

City: _____ State: ____ Zip: _____

Phone: Home _____ Business _____

Patient/Parent Employed by: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Present Position: _____

Spouse/Parent Name: _____

Employed by: _____

Present Position: _____

Purpose of this visit: _____

Other Family Members In this Practice _____

Whom may we thank for this referral? _____

Someone to Notify in Case of Emergency: _____
Phone #

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Please List: _____

_____

_____

_____

_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Method of Payment *Please Circle*

Insurance Credit Card Cash/Check

DENTAL INSURANCE 1st COVERAGE

Employee Name: _____

Employee DOB: _____

Employee SSN: _____

Name of Insurance Co.: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name: _____

Employee DOB: _____

Employee SSN: _____

Name of Insurance Co.: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as they may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I, hereby, authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental care insurance carrier or provider of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care provider.

PATIENT'S or GUARDIAN'S SIGNATURE _____ **DATE:** _____

REGISTRATION FORM

LISAL B. ISAACS, DMD
603 WEST NASH ST.
WILSON, N. C. 27893
252-291-6313

Patient name_____
Date of Birth_____

Medical and Dental History

Today's Date_____

Directions: The following information about your health history is very important for us to provide you with the best possible dental care. Incorrect information may be dangerous to your health. All questions must be answered completely and accurately. If you don't understand a question, or are unsure of your answer, or want to discuss it with the Doctor, circle the number of the question. This Health History will become a part of your dental record and will be considered confidential information.

1. Are you in good health?..... YES NO
2. Has there been any change in your health in the last year?..... YES NO
   If yes, explain_____
   _____
3. Have you ever been hospitalized, had a major operation or serious illness?... YES NO
   If yes, explain _____
   _____
4. Name of your Physician _____ Office phone_____
   Address _____
5. Date of last visit to your Physician _____ Reason for visit_____
6. Are you currently receiving treatment or regular care from your Physician? .... YES NO
   If yes, for what condition?_____
   _____
7. Please list all medications you are currently taking: _____
   _____
   _____
   _____
   _____
8. Are you currently taking or have you taken in the past any of the following medications:
   Fosamax
   Boniva
   Actonel
   Aretia
   Zometa
9. Are you allergic to or have any unusual reactions to any medications? ..... YES NO
   If yes, please explain: _____
10. Are you allergic to or have unusual reactions to local or dental anesthesia? YES NO
    If yes, please explain: _____
11. Do you use any Tobacco products (cigarettes, cigars, smokeless tobacco)? YES NO
    How long? _____ How much per day? _____
12. Do you use any alcohol products? .....YES NO

EMERGENCY CONTACT:

Name	Relationship	Contact Phone Number

OVER

Have you ever had or been treated by a Doctor for:
(Circle your response and underline any conditions that apply)

13. Heart Problems:
    - A. Damaged heart valves..... YES NO
    - B. Artificial heart valves..... YES NO
    - C. Heart murmur..... YES NO
    - D. Rheumatic fever..... YES NO
    - E. Rheumatic heart disease..... YES NO
    - F. Congenital heart problems..... YES NO
    - G. Heart attack..... YES NO
    - H. High blood pressure..... YES NO
    - I. Stroke..... YES NO
    - J. Mitral valve prolapse..... YES NO
    - K. Heart pacemaker..... YES NO

14. Severe or frequent headaches, sinus problems ..... YES NO
15. Blood disorders such as anemia or hemophilia..... YES NO
16. Have you ever had a joint replacement (Knee, Hip or Shoulder)? ..... YES NO
17. Are you allergic to latex? ..... YES NO
18. Have you ever had a blood transfusion? ..... YES NO
19. Breathing problems, emphysema, tuberculosis, other lung problems..... YES NO
20. Asthma, hay fever or hives..... YES NO
21. Stomach or intestinal disease, or ulcers..... YES NO
22. Cancer, x-ray treatment or chemotherapy..... YES NO
23. Tumors or growths ..... YES NO
24. Diabetes or blood sugar problems..... YES NO
25. Hepatitis, jaundice or liver disease..... YES NO
26. Kidney infections or kidney dialysis..... YES NO
27. Stroke, seizures, fainting spells or other neurological problems..... YES NO
28. Syphilis, gonorrhea or genital herpes..... YES NO
29. AIDS, AIDS-related condition or HIV positive..... YES NO
30. Arthritis or rheumatism..... YES NO
31. Phobias, severe anxieties, depression or other mental problems..... YES NO
32. For Women: Are you pregnant or think you are pregnant? ..... YES NO

DENTAL

1. Have you ever been treated for gum disease? ..... YES NO
2. Do you have sores, swellings, blisters on your gums, cheeks, mouth? ..... YES NO
3. Have you had orthodontic treatment to straighten your teeth? ..... YES NO
4. Do you use well water at home? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient (or Parent) Signature: _____ Date: _____

Thank you for your help in completing this History Form. All information that you have provided to us will be used to give you the best dental care possible. All information will be confidential. Thank you for letting our office provide your dental health needs.

Lisal B. Isaacs, DMD, PA
General and Cosmetic Dentistry
(252) 291-6313
603 Nash Street West, STE C
Wilson, North Carolina 27893

Our Financial Policy
Thank you for choosing us for your dental care! We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment.

The following is a statement of our
Financial Policy, which we request you read and sign.
FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, DISCOVER, AMERICAN EXPRESS, VISA or MASTERCARD.
**WE OFFER AFFORDABLE FINANCING OPTIONS FOR TREATMENT.*
*(See our Receptionist for details)**

Regarding Insurance...
Our Practice participates with a select few dental insurance plans. To determine whether or not our practice participates with your particular plan, please speak directly with the receptionist. If your plan is one with which we participate, we will bill and collect according to your plan. All deductibles, co-payments and disallowed charges will be due at the time of service.

If we do not participate with your insurance plan, we will submit your dental claim form as a courtesy to you. Although your insurance company may pay at a higher rate, all deductibles, co-payments and disallowed charges will be due at the time of service for all treatments other than routine cleaning appointments. *In most cases, no payment is required for cleaning appointments.*
We will do all that we can to get the most in benefits reimbursed for you. ***However, we cannot bill your carrier for reimbursement unless you provide us with current insurance information.*** Our practice is committed to providing the best treatment for our patients. However, please be aware that some of the services provided may not be covered or considered above the "usual and customary".

Our practice is committed to providing the best treatment for our patients, while charging what is reasonable and customary for our area. *You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of usual and customary fees.* **If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes the account holders' responsibility.** *(In the event that your account is placed in the hands of an agency for collection, the costs involved, including any attorney fees, will be at the expense of the patient.)*

Regarding Missed Appointments...
When we schedule an appointment, that time is reserved just for you. If you must change an appointment, Please give us at least 24 hours' notice. We'll make every effort possible to verify your appointment at least two days in advance. Please help us serve you better by keeping scheduled appointments. Thank you for reading and understanding our Financial Policy.

Please let us know if you have any questions or concerns.

X _____ Date: _____
Signature of Patient or Responsible Party

X_____
Printed Name

Lisal B. Isaacs, DMD, PA

HIPAA - Patient Consent of Information

Lisal B. Isaacs, DMD, PA, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the dentists and staff of Lisal B. Isaacs, DMD, PA from violating the patient's confidentiality. If there is not a signed consent on file, dentists and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Lisal B. Isaacs, DMD, PA dentists and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing, emailing, or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Lisal B. Isaacs, DMD, PA dentists and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message and email
_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with_____relationship_____
_____ with_____relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Lisal B. Isaacs, DMD, PA Practice.

_____I have declined a copy of Lisal B. Isaacs, DMD, PA Notice of Privacy Practice.

_____ _____
Patient's Signature Date

Lisal B. Isaacs, DMD, PA
603 Nash Street W, Wilson, NC 27893

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 obtained because:

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

_____
_____
_____
_____