



VIZSTARA

The Future of Dentistry

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Preferred method of contact: Home Cell Work Text Email: _____

Address: _____
Street Apartment /Suite/ Floor #
City State Zip Code

Emergency Contact Info: _____
Name Phone Number Relationship to patient

Health Information

Date of Last Physical Exam: _____ Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

Current Medications (please include vitamins, herbal, and non-herbal supplements): _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____



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Referral Information

Whom may we thank for referring you to our practice? Friend Another patient Relative

Dental Office Internet Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: self (if self, skip to employment information) other, relationship to patient: _____

Name: _____

Male Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code

Phone: _____

Insurance Information

(We are not a participating provider. We will submit claims on behalf as a courtesy)

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____



Consent Form

I understand that I am responsible for all payment of dental services provided by this office for myself and/or my dependents. I further understand that full payment is due and payable at the time dental services, including without limitation emergency dental services, are rendered, unless other financial arrangements previously have been made in writing.

In accordance with the foregoing, I understand that regardless of any dental insurance I may have, I will be charged directly for dental services rendered, and I will be directly responsible for payment. I fully understand that this office does not charge insurance companies. However, I understand that, upon my request, this office, as a courtesy, will assist me in completing insurance forms.

I agree that in the event my payments are not received when due, my pending account will accrue a two percent (2%) monthly finance charge (or twenty four (24%) annual finance charge). I further agree that in the event my account is referred for collection, I will agree to pay all legal and other costs related to such collection.

Finally, I authorize this office to contact me at home, work, via telephone, mobile, electronic mail, or otherwise, to discuss payment and collection matters,

I have read, understood and agreed with all of the foregoing.

Signature of patient or guardian Date: _____ Relationship to patient: _____

Signature of guarantor of payment Date: _____ Relationship to patient: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone:
Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
«VIZSTAR» «300 Sylvan Avenue» «Englewood Cliffs, NJ 07632» Phone: (201) 816-4000 Fax: (201) 816-1114

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

**Acknowledgement of Receipt
Notice of Privacy Practices**

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.

HIPAA web-site: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

Please Sign Here If You Refuse to Sign This Acknowledgement*

I, _____, have received acknowledgement of this office's Notice of Privacy Practices.

Signature Date / /

For Office Use:

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

- 0 ____ Individual refused to sign
- 0 ____ Communications barriers prohibited obtaining the acknowledgement
- 0 0 ____ An emergency situation prevented us from obtaining acknowledgement
- 0 0 ____ Other (Please Specify)



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300 Sylvan Ave . Englewood Cliffs, NJ 07632
Phone: 201-816-4000 Fax: 201-816-1114 Email: vizstara@vizstara.com

Patient Photo Release Form

I _____, hereby authorize Vizstara or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, and other social media platforms).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

____ I do not mind if my photographs are used in any of the above stated situations.

____ I only agree to have my teeth shown without any identifying features.

Signed _____ Date _____

7/27/2017



Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least **24 hours** in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. There will be a **fee of \$100** assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Signature of patient or guardian

Date: _____