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:

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

OTHER:

- ☐ _____
- ☐ _____

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.

_____ Date: _____
Signature of patient, parent or guardian

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Consent for Treatment During a Continuing Education Program

I understand, consent to, and authorize that, the dental treatment and clinical procedures to be performed on me will be performed during, and as a part of, a Continuing Education program provided by this office and that such treatment and procedures will be performed on me by program participants and/or instructors as a part of such Continuing Education program.

Prior to reviewing this Consent for Treatment During a Continuing Education Program, I was informed of the dental treatment to be performed on me. My dental needs, recommended treatment, treatment alternatives, and the benefits and potential harm associated with the recommended treatment were thoroughly discussed with me. I had the full opportunity to address concerns and questions, and such concerns and questions were also thoroughly discussed with me to my entire satisfaction. I understand, agree, consent to, and authorize my treatment, as evidenced by the consent to the recommended treatment signed by me and which I hereby reaffirm.

I understand that a program participant is a licensed dentist and will provide any necessary post-program treatment.

I understand that your office is responsible for completion of treatment by a qualified clinician if the program participant required such assistance.

I understand that I have the right, at all times, to refuse or discontinue treatment.

I further understand, consent to, and authorize that, the X-rays, charts, and any other documents, images, or photographs which result from the treatment and clinical procedures performed on me will be used for educational purposes as well as mentorship advertising purposes (not limited to any platform).

I have read, understood and consented to all of the foregoing.

_____Date: _____ Relationship to patient:_____

Signature of patient or guardian

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:
«VIZSTARA» «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.

REVOCATION 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:
☐☐ ____ Individual refused to sign
☐☐ ____ Communications barriers prohibited obtaining the acknowledgement
☐ ☐☐ ____ An emergency situation prevented us from obtaining acknowledgement
☐ ☐☐ ____ Other (Please Specify)
_____
_____
_____