We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health ☺

Patient Information

Name ____

Address ______________________________ Home Phone # ____________

City ____________ State ______ Zip ______ Cell Phone # ____________

Birth Date __________ Social Security # ____________ E-Mail ____________

Occupation ____________________ Employer ______________________

Business Address ______________________ Work # ____________________

Name of Spouse ______________ Birth Date ________ Social Security # __________

Occupation ________________ Employer ______________________

Whom may we thank for referring you? ________________________________

Notify in case of emergency ______________________ Phone # ____________

Primary Insurance

Person Responsible for Account ______________________________________

Relation to patient ____________ Social Security # ___________ Birth Date ______

Address *(if different from patient)*______________________________________

City ____________ State ______ Zip ______ Phone # ________________

Dental Insurance Company ____________________ Phone # ________________

Policy # ____________________

Is there additional insurance? Y_____ N _____

If you have dental insurance, we will be happy to submit on your behalf. Please understand we are not responsible for your coverage and benefits. This is a contract between you and your employer. We will do our best to help guide you in any way we can.

For Office Use Only

2016 __________ *2017* __________

2018 __________ *2019* __________

Dental History

What would you like us to do today? ____

Are you in discomfort today? ____

Former Dentist ____________________________ Phone # _______________________

Address ________________________ City ________________ State ___________

Date of last dental care ___________________ Date of last x-rays _____________________

Mark **Y** for yes or **N** for no if you have or have not had the following:

Bad Breath ____ Sensitivity to sweets ____ Sensitivity to cold ____ Sensitivity to hot ____

Food collection between teeth ____ Loose teeth ____ Broken fillings ____

Periodontal treatment ____ Bleeding Gums ____ Grinding or clenching teeth ____

Did you ever wear braces ____ Did you ever have a root canal ____ Clicking or popping jaw ____

Do you wear dentures or partials ____ If so, are you happy with your present dentures _________

How do you feel about the appearance of your teeth? ________________________________

Are you interested in whitening? _____________

Medical History

Physician's Name ____________________________ Phone # _______________________

Address ___________________________ City __________________ State ___________

Have you had any serious illness or operations? _____________________________________

Are you under medical treatment now? ____

Have you ever had a blood transfusion? ____ Have you ever taken Fen-Phen/Redux? ____

Women: Are you pregnant? ____ Estimated Due Date________Nursing? ____ Taking birth control? ____

Mark **Y** for yes or **N** for no if you have or have not had the following:

____AIDS/HIV Positive	____Artificial Joints	____Cancer	____Epilepsy
____Anemia	____Angina	____Chemical Dependency	____HBP
____Asthma	____Blood Disease	____Diabetes	____Heart Murmur
____Liver Disease	____Kidney Disease	____Mitral Valve Prolapse	____Rheumatic Fever

List medications you are currently taking ____

____

List drug allergies, if any____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____Date ________________

OFFICE PAYMENT POLICY

Our mission is to deliver the finest, most cost effective dental treatment available today. Following diagnosis, the doctor will advise you of the recommended plan for treatment.

Payment for today's visit and your future visits is due at the time of treatment. If you have insurance we will submit claims for you, *but co-payments and deductibles are due at the time of service.* We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore we offer several alternative payment programs for your convenience. Please note that we do not guarantee your insurance payment. We will do our best to estimate your insurance co-pays. This contract is between you and your employer.

1. Cash or Check

2. Mastercard / Visa / American Express or Discover

3. Monthly Payment Plan through Care Credit or Citi Health – This is a line of credit used solely by health care providers and does not in any way affect the balances of your other credit cards. There is no annual fee. You may also be eligible for a deferred interest plan for 3 to 12 months or more depending on your balance.
   It takes only a few minutes to process an application. We are more than happy to answer any questions you may have regarding this monthly payment plan.

Please indicate below the form of payment you wish to use to settle your account:

( ) Cash or Check

( ) Visa/Mastercard/American Express or Discover

( ) Care Credit or Citi Health – If you choose this option, please ask to complete an application.

Please note that any account that is more than 60 days overdue, regardless of payment option, will be assessed a 1 ½ % finance charge per month. If any accounts become delinquent you will also incur collection & attorney fees, if applicable. We appreciate your consideration of this.

OFFICE CANCELLATION POLICY

An appointment is time "reserved" for you. We will do our best to respect your time and ask that you do the same for our practice. ***If you need to cancel or change an appointment****, we require 48 hours notice. Insufficient notice to cancel or change an appointment will result in a fee.*

______________________________ ____________

Signature of Patient or Responsible Party Date

JACK J. ZUBER, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF HEALTH INFORMATION IS IMPORTANT TO US

We, at Dr.Jack J. Zuber's office, are committed to treating and using protected health information ("PHI") about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This notice is effective 4-14-2003, and applies to all protected health information as defined by law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use or disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family or friends you approve.

PAYMENT: We may use or disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, review the competence or qualifications, of healthcare professionals, evaluating, practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATIONS: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI(Personal Health Information), or alternative means of communication to ensure privacy.

MARKETING HEALTH-RELATED SERVICES: We will NOT use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law or national security activities.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

APPOINTMENT REMINDERS: We may use or disclose your information to provide you with appointment reminders (such as voicemails messages, postcards, or letters).

ACCESS: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you $25.00 to locate and copy your information, and postage if you want copies mailed to you.

AMENDMENT: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternate location, you may complain to the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us to the US Department of Health and Human Services.

A Privacy/Contract Officer has been designed for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contract Officer or call our office at 973-379-1110.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

Print Patient's Name **Date**

I, ______________________________________, have received

A copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, ______________________________________, consent to the use and disclosure of my

Personal health information by your office during Treatment, Billing/Payment and Dental Office Operations as outlined in the Notice of Privacy Practices.

OPTIONAL- I authorize that all information pertaining to my treatment and /or medical information may be discussed with the following person:

____