Thank you for choosing the office of DR. JOHN ZARGARI "The more you see us, the more you will smile."

Patient Information

Name _____ Nickname _____
Last Name First Name Initial
Email _____
SS # _____ Home phone _____ Cell or Pgr _____
Address _____ Apt. _____
City _____ State _____ Zip _____
Sex ❑M ❑F Birthdate ___ _____ ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced
Patient employed by _____ Occupation _____
Business address _____ Business phone _____
Is anyone in your family a patient here _____
In case of emergency who should we notify _____ Phone _____
Whom may we thank for referring you? _____

Dental History

Reason for today's visit _____
Former dentist/City & State _____
Date of last dental care _____
Check(✓) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth
- ❑ Broken fillings
- ❑ Periodontal treatment
- ❑ Biting lips or cheeks
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth
- ❑ Sensitivity to cold

Do you like your smile? 1 2 3 4 5
please circle (no) (yes)

Medical History

Physician's name _____ Date of last visit _____
Have you had any serious illnesses or operation? ❑Yes ❑No
Check(✓) if you have had any of the following:

- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe _____
- ❑ Hepatitis
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tobacco Habit
- ❑ Tuberculosis

For Women:
Currently Pregnant
❑ Yes ❑ No
Nursing ❑ Yes ❑ No

MEDICATIONS
list medications you are currently taking

_____
_____
_____

ALLERGIES

_____
_____
_____

Authorization

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

John Zargari DDS, PA
2650 Maguire Road
Ocoee, FL 34761

RE: Cancellation of Appointments

We feel that a dedicated and reserved appointment time is the best way that we can accommodate your dental needs in a timely manner and minimize the time you spend in our “waiting room”.

With the exception of an occasional emergency, we are proud to see you on time. We see a limited number of patients on any given day. Our goal is not one of high volume, but to care for fewer people, exceptionally well.

When a patient does not come to their scheduled appointment or does not give at least two business days cancellation notice, this becomes lost time in which we can not help another patient. We do not over schedule a waiting room full of patients from which we can now “plug in” to this newly created “open” time. It is for these reasons that we ask that you to provide us with a minimum of two business days notice of any change to your appointment.

A fee will be charged to your account for not honoring this policy. For a missed appointment scheduled with our hygienists and/or with Dr. Zargari, you will be charged a fee of $50 per hour. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances.

Thank you for helping us care for our best patients, like you!

_____ _____

Patient’s Signature Date

JOHN ZARGARI DDS, PA
PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your orthodontist, oral surgeon, etc.) in connection with our rendering general dentistry treatment to you (i.e. to determine the results of cleanings, surgeries, restorative, etc.);
- To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. the Florida Dental Association, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;

- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Review an accounting of certain disclosures made by us of your protected health information; and
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information.
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use of disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____

Patient Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
JOHN ZARGARI DDS, PA
Cosmetic and General Dentistry

Section A: Patient Giving Consent

Name: _____

Address: _____

_____

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Social Security Number: _____

Section B: To the patient – 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 necessary treatment, payment activities, and healthcare operations which includes other healthcare professionals directly related to your treatment and insurance companies.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the 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:

Deanne Porter or Dr. John Zargari
2650 Maguire Road
Ocoee, FL 34761
Telephone: 407-654-0070 / Fax: 407-654-0087

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.

Who else is allowed access information regarding your treatment or account status?

Name: _____ Telephone: _____

Name: _____ Telephone: _____

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 healthcare options.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient: _____