

OUT OF THIS WORLD DENTISTRY

David m. Babcock d.m.d

Name _____ Preferred Name _____
Mr. Mrs. Ms. Dr. First Middle Last

Sex: M ___ F ___ Birth date _____ Age _____ Reason for this visit? _____

Who may we thank for referring you to our office? _____

GENERAL INFORMATION

This information is requested for financial and credit purposes.

Address _____ City _____ ST _____ Zip _____

Hm Phone () _____ Cell () _____ SS# _____ - _____ - _____ DI# _____

___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

Employer _____ Wrk Phone () _____ Ext. _____

Address _____ City _____ ST _____ Zip _____

E-Mail Address _____

Spouse Information

Name _____ Birth Date _____ SS# _____ - _____ - _____

Employer _____ Wrk Phone () _____ Ext. _____

In the Event of an Emergency

Is there someone who lives near you that we should contact?

Name _____ Relationship _____

Home Phone () _____ Wrk Phone () _____

Person Responsible for Account

Name _____ Relationship _____ Hm Phone () _____ Wrk Phone () _____

Billing Address _____ City _____ ST _____ Zip _____

Employer _____ SS# _____ - _____ - _____ DI# _____

Primary Dental Insurance

Name of subscriber _____ Subscribers ID _____ Grp No. _____

Name of Insurance Co. _____ Phone No. _____

Address _____ City _____ ST _____ Zip _____

Policy holders employer _____

Secondary Dental Insurance

Name of subscriber _____ Subscribers ID _____ Grp No. _____

Name of Insurance Co. _____ Phone No. _____

Address _____ City _____ ST _____ Zip _____

Policy holders employer _____

Assignment of Benefits: I authorize Out of this Word Dentistry to furnish my insurance company with all information to process my dental claims.

I authorize the above named insurance company to pay all benefits due me directly to Out of this World Dentistry.

I understand I am responsible for charges not covered by this assignment .

Signed (insured Person) _____ Date _____

NOTICE: There will be a \$25 charge for broken appointments without 24hr hour notice. Initial _____

PLEASE SEE REVERSE SIDE

Dental History

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes ___ No ___

Do you require antibiotics before dental treatment? Yes ___ No ___

Your current dental health is Good ___ Fair ___ Poor ___

Are you happy with your existing dental work? Yes ___ No ___

Please explain: _____

Do you now or have you ever had any pain/discomfort in you jaw joint (TMJ/TMD)? Yes ___ No ___

Do your gums ever bleed? Yes ___ No ___

Are any of your teeth loose? Yes ___ No ___

Have you ever had a serious/difficult problem associated with previous dental work? Yes ___ No ___

If Yes, please explain: _____

Previous Dentist _____

Last Visit Date _____ Date of last full mouth or panorex X-ray _____

What is most important about a relationship with your dentist? _____

Appearance Dentistry

If you could change anything about your smile, what would it be? _____

MEDICAL INFORMATION

Your current physical health is Good ___ Fair ___ Poor ___

Are you currently under the care of a physician Yes ___ No ___

Please explain _____

Physician's Name _____ Phone # _____ Date of Last Visit _____

Are you taking any prescriptions or over-the-counter drugs? Yes ___ No ___ Please list each one _____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex	Y N Aspirin	Y N Dental Anesthetics
Y N Sulfa	Y N Erythromycin	Y N Codeine	Y N Other _____	

Have you ever had any of the following diseases or medical problems?

Yes	No		Yes	No		Yes	No	
___	___	Heart Attack	___	___	Heart Surgery	___	___	High Blood Pressure
___	___	Stroke	___	___	Pace Maker	___	___	Low Blood Pressure
___	___	Cancer/Chemo	___	___	Mitral Valve Prolapse	___	___	Blood Transfusion
___	___	Heart Murmur	___	___	Kidney/Liver Problems	___	___	Fever Blisters
___	___	Rheumatic Fever	___	___	Artificial Bones/Joints	___	___	Psychiatric Problems
___	___	Heart Problems	___	___	Artificial Valves	___	___	Diabetes
___	___	HIV+/Aids	___	___	Sinus Problems	___	___	Respiratory Problems
___	___	Tuberculosis (TB)	___	___	Epilepsy	___	___	Fainting Spells
___	___	Seizures	___	___	Venereal Disease	___	___	Ulcers
___	___	Colitis	___	___	Congenital Heart Defect	___	___	Radiation Treatment
___	___	Asthma	___	___	Hepatitis A	___	___	Hepatitis B
___	___	Arthritis	___	___	Hospitalized for any reason	___	___	Glaucoma
___	___	Previous Drug/Alcohol Abuse	___	___	Hemophilia/Abnormal Bleeding			

Please discuss any serious medical condition(s) that you have ever had: _____

For Women

	Yes	No	
Are you taking birth control pills?	___	___	
Are you Pregnant?	___	___	Week # if yes ___
Are you Nursing	___	___	

Health History Update (for follow-up visits only)

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

Date _____ Signature _____ DDS Initials _____

PATIENT'S NAME: _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Babcock and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide) analgesic, therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction on side effects. Which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely permanent numbness, and muscle soreness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm if any which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: _____ Date _____
(Patient, legal guardian, or authorized agent of patient)

Witness: _____ Date _____

Office Financial Policies and Truth-in-Lending Statement

Our financial policy is to receive payment in full by the time treatment is completed. If you have dental insurance, your estimated co-payment will be required at the time of service. If this is not convenient for you, we do accept VISA, Mastercard, Discover, and American Express. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patient or assist in making collections received to the patients account as a courtesy. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. You will be billed for any remaining balance that is not paid by your insurance.

Interest, at the annual rate of 18% (compounded monthly), will be added to any balance over 60 days, starting from the date the charge was made unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, to said dentists or his assignee at the time said services are rendered, or within ninety (90) days of billing if credit shall be extended. Any account over 90 days delinquent will be turned over to a collection agency. If this account is assigned to an outside agency for collection I/we agree to pay all attorney fees, court costs, process service fees, filing fees, and any charges or commissions, up to 50% that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

Missed appointment policy

A \$25.00 charge will be added to all accounts for each missed appointment with less than 24 hour notice.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family member are entitled, including private dental insurance and other health plan benefits otherwise payable to the undersigned to Out of this World Dentistry.

I certify that I have answered all questions on this form accurately and to the best of my knowledge.
I hereby agree to abide by the conditions outlined hereon.

Signature of Patient, Parent or Guardian

Date

Relationship to Patient

OUT OF THIS WORLD DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

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 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:

Contact Person: Dr. Cory M. Stark

Telephone: 571-6751 Fax: 571-4156

Address: 112 E. 12450 So. Draper UT 840720

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

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCACTION 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: _____

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