



## GENERAL INFORMATION

This information is requested for financial and credit purposes.

**FATHER** (full name) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Hm Phone ( ) \_\_\_\_\_ SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Wrk Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Drivers License Number \_\_\_\_\_

**MOTHER** (full name) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Hm Phone ( ) \_\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Wrk Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Name of nearest relative \_\_\_\_\_ Hm ( ) \_\_\_\_\_ Wrk ( ) \_\_\_\_\_

Relation to which parent and relation to patient \_\_\_\_\_

## INSURANCE INFORMATION

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

## FINANCIAL AGREEMENT

Our financial policy is to receive payment in full by the time treatment is completed. If this is not convenient for you, we do accept VISA, Mastercard, and American Express and can direct you to other sources of credit. (CareCredit) If you have dental insurance, your estimated co-payment will be required at the time of service. 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. 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.

**SIGNATURE** \_\_\_\_\_ **RELATIONSHIP TO CHILD** \_\_\_\_\_ **DATE** \_\_\_\_\_

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# OUT OF THIS WORLD DENTISTRY

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### 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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