OUT OF THIS WORLD
DENTISTRY & ORTHODONTICS

PATIENT NAME_____ PREFERRED NAME_____
Mr. Mrs. Ms. Miss First Middle Last

DATE OF BIRTH _____ AGE _____ SEX: M____ F____

REASON FOR THIS DENTAL VISIT:_____

HOW DID YOU FIND OUT ABOUT US? DR./DENTIST*____ EXISTING PATIENT*____ INSURANCE*____ INTERNET SEARCH*____

OUR WEBSITE____ LOCAL DIRECTORY*____ SCHOOL*____ OTHER*:____ PLEASE SPECIFY*:_____

HAVE WE SEEN OTHER IMMEDIATE FAMILY MEMBERS?____ NAMES:_____

GENERAL INFORMATION - FOR FINANCIAL PURPOSES

ADDRESS _____ CITY_____ ST_____ ZIP_____

PHONE: HOME# _____ CELL# _____ WORK# _____

EMAIL _____

*SSN _____ *AT A MINIMUM - LAST 4 DIGITS OF SSN IS REQUIRED

EMPLOYER _____ EMP. ADDRESS _____ EMP. PHONE _____

SPOUSE INFORMATION

NAME _____ BIRTHDATE _____ SSN _____-_____-_____

CELL # _____ EMPLOYER _____ WORK # _____

IN THE EVENT OF EMERGENCY - Is there someone who lives near you that we should contact?

NAME _____ RELATIONSHIP _____

HOME # _____ CELL # _____ WORK # _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME _____ RELATIONSHIP _____ BIRTHDATE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE: HOME# _____ CELL# _____ WORK# _____

EMAIL _____ EMPLOYER _____

*SSN _____ *AT A MINIMUM - LAST 4 DIGITS OF SSN IS REQUIRED

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

POLICY HOLDER NAME _____ POLICY HOLDER DATE OF BIRTH _____

POLICY HOLDER EMPLOYER _____ ID#_____ GROUP#_____

INSURANCE COMPANY _____ INSURANCE PHONE _____

INSURANCE ADDRESS _____ CITY _____ ST/ZIP_____

SECONDARY DENTAL INSURANCE

POLICY HOLDER NAME _____ POLICY HOLDER DATE OF BIRTH _____

POLICY HOLDER EMPLOYER _____ ID#_____ GROUP#_____

INSURANCE COMPANY _____ INSURANCE PHONE _____

INSURANCE ADDRESS _____ CITY _____ ST/ZIP _____

ASSIGNMENT OF BENEFITS: I authorize Out Of This World Dentistry to provide my insurance company with all information necessary to process my dental claims. I authorize the above named insurance company to pay all benefits (due to me directly) to Out Of This World Dentistry. I understand that I am responsible for charges not covered by this assignment. **SIGNED (INSURED PERSON)** _____ Date _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is an integral part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your dental care. Thank you for answering the following questions.

ARE YOU UNDER A PHYSICIAN'S CARE NOW? ☐ YES ☐ NO IF YES _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR SURGERY? ☐ YES ☐ NO IF YES _____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ☐ YES ☐ NO IF YES _____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? ☐ YES ☐ NO IF YES _____

DO YOU TAKE OR HAVE YOU TAKEN PHEN-FEN OR REDUX? ☐ YES ☐ NO IF YES _____

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY OTHER MEDICATIONS CONTAINING BIOPHOSPHATES? ☐ YES ☐ NO IF YES _____

ARE YOU ON A SPECIAL DIET? ☐ YES ☐ NO IF YES _____

DO YOU USE TOBACCO? ☐ YES ☐ NO IF YES _____ E-CIGARETTE? ☐ YES ☐ NO IF YES _____

WOMEN: ARE YOU... ☐ PREGNANT/TRYING TO GET PREGNANT? ☐ NURSING? ☐ TAKING ORAL CONTRACEPTIVES?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX ☐ SULFA DRUGS
☐ LOCAL ANESTHETICS ☐ OTHER _____

DO YOU USE CONTROLLED SUBSTANCES? ☐ YES ☐ NO IF YES _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? Y = YES, N = NO

AIDS/HIV POSITIVE	☐ Y ☐ N	EXCESSIVE BLEEDING	☐ Y ☐ N	MITRAL VALVE PROLAPSE	☐ Y ☐ N
ALZHEIMER'S DISEASE	☐ Y ☐ N	EXCESSIVE THIRST	☐ Y ☐ N	OSTEOPOROSIS	☐ Y ☐ N
ANAPHYLAXIS	☐ Y ☐ N	FAINTING SPELLS/DIZZINESS	☐ Y ☐ N	PAIN IN JAW JOINTS	☐ Y ☐ N
ANEMIA	☐ Y ☐ N	FREQUENT COUGH	☐ Y ☐ N	PARATHYROID DIESEASE	☐ Y ☐ N
ANGINA	☐ Y ☐ N	FREQUENT DIARRHEA	☐ Y ☐ N	PSYCHIATRIC CARE	☐ Y ☐ N
ARTHRITIS/GOUT	☐ Y ☐ N	FREQUENT HEADACHES	☐ Y ☐ N	RADIATION TREATMENTS	☐ Y ☐ N
ARTIFICIAL HEART VALVE	☐ Y ☐ N	GLAUCOMA	☐ Y ☐ N	RECENT WEIGHT LOSS	☐ Y ☐ N
ARTIFICIAL JOINT	☐ Y ☐ N	HAY FEVER	☐ Y ☐ N	RENAL DIALYSIS	☐ Y ☐ N
ASTHMA	☐ Y ☐ N	HEART ATTACK/FAILURE	☐ Y ☐ N	RHEUMATIC FEVER	☐ Y ☐ N
BLOOD DISEASE	☐ Y ☐ N	HEART MURMUR	☐ Y ☐ N	RHEUMATISM	☐ Y ☐ N
BLOOD TRANSFUSION	☐ Y ☐ N	HEART PACEMAKER	☐ Y ☐ N	SCARLET FEVER	☐ Y ☐ N
BREATHING PROBLEMS	☐ Y ☐ N	HEART TROUBLE/DISEASE	☐ Y ☐ N	SHINGLES	☐ Y ☐ N
BRUISE EASILY	☐ Y ☐ N	HEMOPHILIA	☐ Y ☐ N	SICKLE CELL DISEASE	☐ Y ☐ N
CANCER	☐ Y ☐ N	HEPATITIS A	☐ Y ☐ N	SINUS TROUBLE	☐ Y ☐ N
CHEMOTHERAPY	☐ Y ☐ N	HEPATITIS B OR C	☐ Y ☐ N	SPINA BIFIDA	☐ Y ☐ N
CHEST PAINS	☐ Y ☐ N	HERPES	☐ Y ☐ N	STOMACH/INTESTINAL DISEASE	☐ Y ☐ N
COLD SORES/FEVER BLISTERS	☐ Y ☐ N	HIGH BLOOD PRESSURE	☐ Y ☐ N	STROKE	☐ Y ☐ N
CONGENITAL HEART DISORDER	☐ Y ☐ N	HIGH CHOLESTEROL	☐ Y ☐ N	SWELLING OF LIMBS	☐ Y ☐ N
CONVULSIONS	☐ Y ☐ N	HIVES OR RASH	☐ Y ☐ N	THYROID DISEASE	☐ Y ☐ N
CORTISONE MEDICINE	☐ Y ☐ N	HYPOGLYCEMIA	☐ Y ☐ N	TONSILLITIS	☐ Y ☐ N
DIABETES	☐ Y ☐ N	IRREGULAR HEARTBEAT	☐ Y ☐ N	TUBERCULOSIS	☐ Y ☐ N
DRUG ADDICTION	☐ Y ☐ N	KIDNEY PROBLEMS	☐ Y ☐ N	TUMORS OR GROWTHS	☐ Y ☐ N
EASILY WINDED	☐ Y ☐ N	LEUKEMIA	☐ Y ☐ N	ULCERS	☐ Y ☐ N
EMPHYSEMA	☐ Y ☐ N	LIVER DISEASE	☐ Y ☐ N	VENEREAL DISEASE	☐ Y ☐ N
EPILEPSY OR SEIZURES	☐ Y ☐ N	LOW BLOOD PRESSURE	☐ Y ☐ N	YELLOW JAUNDICE	☐ Y ☐ N
		LUNG DISEASE	☐ Y ☐ N		

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED? ☐ YES ☐ NO IF YES: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE *DR. SIGN*

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

ARE YOU CURRENTLY IN PAIN? YES_____ NO_____ EXPLAIN _____

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 YOUR 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 _____ LOCATION _____

LAST DENTAL VISIT DATE _____ LAST DATE FULL MOUTH OR PANORAMIC X RAY _____

WHAT IS THE MOST IMPORTANT IN THE RELATIONSHIP WITH YOUR DENTIST? _____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD IT BE? _____

_____

OFFICIAL POLICIES AND TRUTH-IN-LENDING STATEMENT

This dental office's financial policy is to receive payment in full at the time treatment is completed. If the patient has dental insurance, the estimated co-payment will be required at the time of service. If this is not convenient, VISA, MasterCard, Discover, and American Express and Care Credit are other accepted methods of payment. As a condition of dental treatment by this office, any other financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment. Emergency dental services, or any dental services performed without previous financial arrangements, require payment in full at the time services are rendered.

Should patient go 12 months without a dental visit at Out Of This World Dentistry (OOTWD), unless other advance arrangements have been made, for legal and ethical reasons, OOTWD must consider the professional relationship discontinued and would require completion of a new patient agreement for further visits.

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 for the patient or assist in making collections received to the patient 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. Patient will be billed for any remaining balance that is not paid by insurance. Insurance payments quoted for dental treatment are estimates and are not guaranteed.

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 patient/responsible party agrees to pay all attorney fees, court costs, process service fees, filing fees, and any charges or commissions, a 40% will 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, on cell or at my workplace to discuss matters related to this form.

- 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.

MISSED APPOINTMENT POLICY

Missed or cancelled appointments, with less than 24 hr notice, will be charged $26 for a preventive appointment and $50 for a treatment appointment.

I, _____, give consent for Out Of This World Dentistry to send FINAL billing notifications in the following manner:

☐ **Via Text Message to #: ___-___-____ OR ☐ Via Certified Mail to the address on file, and will incur a postage fee of $6.65 per notice.**

I hereby agree to abide by the conditions outlined hereon.

_____

Signature of Patient, Parent or Guardian Printed Name Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME(S) _____

ADDRESS _____

PHONE _____ EMAIL _____

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, insurance billing 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 anytime by contacting:

CONTACT PERSON: Dr. Cory M. Stark
PHONE: 801-571-6751 FAX: 801-571-4156
ADDRESS: 112 EAST 12450 SOUTH #100 DRAPER, UT 84020

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us a 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, insurance billing 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(S)_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Completed Consent will be in the patient's chart.

Dental Treatment Consent For COVID-19 Pandemic

1. I knowingly and willingly consent to dental treatment at Out Of This World Dentistry by Dr._____ and any designated associates and employees during the COVID-19 pandemic.

2. I understand that Dr._____ is following CDC guidelines and a mandate by the Utah Department of Health effective March 25, 2020 restricting nonessential dental procedures. I have been given an explanation why the procedures recommended for me to undergo fall under urgent care or emergency procedures. I understand that dental visits are therefore limited to the treatment of pain, infection, and other conditions that significantly inhibit normal operation of teeth and mouth or could be detrimental to overall health and are thus considered urgent or emergent, and issues that could be detrimental to overall dental and physical health if not treated within the next several months. I confirm that I am seeking treatment for a condition that qualifies and requires essential, emergent or urgent care.

3. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not given the current limitations and availability in COVID-19 viral testing. I understand that emergency or urgent dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the spray can linger in the air for hours, which can transmit the COVID-19 virus.

4. Risk of transmission: I understand that due to the frequency of visits of other emergency or urgent care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though CDC and Utah Department of Health mandates are being observed.

5. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
   A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celcius or higher
   B. Shortness of breath
   C. Dry cough
   D. Runny nose
   E. Sore throat.
   F. Diminished sense of taste and smell

6. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days.

7. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date

Witness to signature	Date