OUT OF THIS WORLD
DENTISTRY & ORTHODONTICS

PATIENT NAME _____ **NICKNAME** _____
First Middle Last

SEX: M_____ F_____ BIRTH DATE _____ IS THIS YOUR CHILD'S FIRST DENTAL VISIT? _____

DATE OF LAST VISIT_____ REASON FOR THIS VISIT? _____ IS YOUR CHILD IN PAIN?_____

WHAT IS YOUR CHILD'S ATTITUE TOWARDS PREVIOUS DENTAL CARE?_____

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

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

OUR WEBSITE_____ LOCAL DIRECTORY*_____ SCHOOL*_____ OTHER*:_____ PLEASE SPECIFY*:_____

MEDICAL INFORMATION

IS PATIENT UNDER DOCTOR'S CARE NOW?_____ FOR WHAT REASON?_____ DR. NAME:_____

IS PATIENT TAKING ANY MEDICATION OR DRUGS?_____ WHAT KIND:_____ REASON:_____

HAS PATIENT EVER BEEN HOSPITALIZED?_____ WHEN?_____ REASON:_____

DOES YOUR CHILD HAVE ANY BEHAVIORAL OR NEUROPSYCHIATRIC DISORDERS? ADD_____ ADHD_____ AUTISM_____

ASPERGERS_____ OTHER (SPECIFY)_____ IS HE/SHE ON MEDICATION FOR THESE CONDITIONS?_____

IS YOUR CHILD ALLERGIC TO: PENICILLIN/AMOXICILLIN_____ LATEX_____ OTHER:_____

HAS YOUR CHILD HAD A HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?

AIDS/HIV+	Y N	EARACHES	Y N	LIVER DISEASE	Y N
ANEMIA	Y N	EPILEPSY/SEIZURES	Y N	PREMATURE BIRTH	Y N
ASTHMA	Y N	GASTROINTESTINAL DISEASE	Y N	RADIATION TREATMENTS	Y N
BLOOD DISORDER	Y N	HAY FEVER	Y N	RESPIRATORY DISEASE	Y N
BONE DISORDER	Y N	HEART MURMUR	Y N	RHEUMATIC FEVER	Y N
BRAIN INJURY	Y N	HEART DISEASE	Y N	SCARLET FEVER	Y N
CANCER	Y N	HEPATITIS A, B OR C	Y N	SICKLE CELL DISEASE/TRAIT	Y N
CEREBRAL PALSY	Y N	KIDNEY PROBLEMS	Y N	SPEECH DISORDER	Y N
DIABETES	Y N	LEUKEMIA	Y N	SPINA BIFIDA	Y N
HAS YOUR CHILD EVER HAD A SERIOUS ILLNESS NOT LISTED ABOVE? Y N				TUMORS OR GROWTHS	Y N

IF YES FOR SERIOUS ILLNESS NOT LISTED, PLEASE EXPLAIN: _____

DENTAL INFORMATION

WAS YOUR CHILD BOTTLE FED? YES NO UNTIL WHAT AGE?_____ OR BREAST FED?_____ UNTIL WHAT AGE?_____

DOES YOUR CHILD HAVE ANY MOUTH HABITS? Y N FINGER/THUMB SUCKING_____ PACIFIER_____ OTHER_____

HAS PATIENT EVER HAD ANY INJURIES TO FACE, MOUTH OR HEAD? Y N WHEN?_____ EXPLAIN_____

DOES YOUR CHILD BRUSH REGULARLY? Y N DOES AN ADULT ASSIST WITH BRUSHING? Y N

DOES YOUR CHILD FLOSS REGULARLY? Y N DOES AN ADULT ASSIST IN FLOSSING? Y N

HAS EITHER PARENT OR CHILD BEEN TREATED ORTHODONTICALLY?_____ WHO?_____

DESCRIBE YOUR CHILD (CIRCLE): OUTGOING SHY ANXIOUS STUBBORN FRIGHTENED REGULAR KID OTHER:_____

HOW MAY WE HELP MAKE THIS A POSITIVE EXPERIENCE FOR YOUR CHILD? _____

_____

GENERAL INFORMATION (FOR FINANCIAL PURPOSES)

PARENT/GUARDIAN (1) _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY_____ ST_____ ZIP_____

PHONE: HOME# _____ CELL# _____ WORK# _____

EMAIL _____ BIRTHDATE _____

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

EMPLOYER _____ EMP. ADDRESS _____ EMP. PHONE _____

MARITAL STATUS _____ IF MARRIED, SPOUSE NAME _____

PARENT/GUARDIAN (2) _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY_____ ST_____ ZIP_____

PHONE: HOME# _____ CELL# _____ WORK# _____

EMAIL _____ BIRTHDATE _____

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

EMPLOYER _____ EMP. ADDRESS _____ EMP. PHONE _____

MARITAL STATUS _____ IF MARRIED, SPOUSE NAME _____

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_____

POLICY HOLDER RELATIONSHIP TO PATIENT _____

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_____

POLICY HOLDER RELATIONSHIP TO PATIENT _____

***IF SECONDARY INS, ADDITIONAL INFORMATION IS NEEDED:** ARE PATIENT'S PARENTS DIVORCED? Y N IF YES...

WHO DOES PATIENT LIVE WITH? _____ WHO IS REQUIRED TO HOLD DENTAL INS.? _____

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.

FINANCIAL POLICY

Payment in full is required upon completion of dental treatment. We accept VISA, MasterCard, America Express, HSA cards and can direct you to other sources of credit, such as Care Credit. 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 not paid by your insurance. Interest, at the annual rate of 18% (compounded monthly), will be added to any balance over 60 days from the date charges occurred. Any account over 90 days past due will be turned over to a collection agency, including attorney fees, court costs, processing fees, filing fees and any charges or commissions. A 40% fee will be assessed if sent to a collection agency. Should you go 12 months without a dental visit at Out Of This World Dentistry (OOTWD), unless other arrangements have been made in advance, for legal and ethical reasons, OOTWD must consider the professional relationship discontinued and would require completion of a new patient agreement for further dental visits.

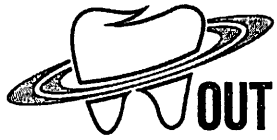
By signing below, I accept and agree as the responsible party on this account.

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, this will incur a postage fee of $6.65 per notice.**

PRINTED NAME _____ **SIGNATURE** _____ **DATE** _____



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