Paul M. Huffaker, DMD, PLLC
134 S. Main Street
Centerville, UT 84014
385-245-8247

Patient Name _____ Gender ____ Birthdate _____/_____/_____

Home Address _____ Phone _____ ☐ Cell

City, Zip _____ Phone _____ ☐ Cell

Employer Name and Address _____ Work Phone _____

Spouse's Name _____ Birthdate _____/_____/_____

Preferred Reminders (circle one): Call Text Email: _____

How did you hear about us? Friend Internet Print ad Insurance company Other: _____

Responsible Party _____ Relation to Patient _____ Birthdate ____/____/____

Home Address _____ Phone _____ ☐ Cell

Employer Name and Address _____ Work Phone_____

Dental Insurance _____ Address _____

Name of Policy Holder _____ Birthdate ___/___/___ Policy # _____

Secondary Insurance Coverage _____ Address _____

Name of Policy Holder _____ Birthdate ___/___/___ Policy # _____

Our Policy: Payment is due at time of service, unless a financial agreement form is completed; however, our requirements for maintaining your account in good standing are that at least one payment per month be made on your account. We reserve the right to charge interest at 1.5% per month (18% per annum) on accounts sixty (60) days past due (minimum service charge $2.00 per month, which is the cost of mailing a monthly statement).

In the event that full payment for charges incurred for dental care is not made, I agree to pay all cost of collection, including a 50% Collection Agency Commission, reasonable attorney's fees and court costs. I also agree to submit myself to the jurisdiction of the courts.

Initial: ___

Consent to Use or Disclose Dental and Medical Information

I authorize Paul M. Huffaker, DMD, PLLC to use and disclose the dental, medical, and health information of the above named patient for the following purpose(s):

- Treatment: Includes activities performed by the dentists as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.
- Payment: Includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement of your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriate charges, pre-certification and pre-authorization of services.
- Health Care Operations: Includes associated business and administrative affairs of this office.

You have the right to revoke this Consent. However, you must revoke this Consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within which this Consent is effective.

_____ _____

Date Signature of patient or guardian or other person authorized by law