SMILE MONTANA DENTAL CENTER
105 Nucleus Ave
Columbia Falls, MT 59912

Patient Information:

Patients Name: _____ SS: _____ DOB: _____

Mailing Address:_____City: _____State: _____Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Email: _____

Married Single Widowed Separated Divorced **Minor Under 18**

How did you hear about our office? _____

Emergency Contact:_____Phone:_____

Responsible Party's Information: (If patient is under 18)

Name: _____SS: _____ DOB: _____

Mailing Address:_____City: _____State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____ Email:_____

Spouse's Information

Spouses Name: _____ SS: _____ DOB: _____

Mailing Address:_____ City: _____State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Email: _____

Insurance Information: **(If you have an insurance card please provide it to the front desk to scan)**

Insurance Name: _____Employer: _____

Insurance Phone #: _____ Subscriber Name: _____

DOB: _____Sub Social Sec #: _____Subscriber #: _____Group#_____

Consent:

I will answer all health questions to the best of my knowledge: (_____(initials)) I hereby authorize the performance of dental services upon the above-named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the Doctor.

Signature:_____**Date:**_____

Relationship to Patient if the patient is under 18:

_____

Dental History

Reason for today's visit? _____ Are you nervous about dental care? _____

Previous Dentist:_____ Date of last visit: _____

Do you have current x-ray's or records at another office? _____ **Where:** _____

How often do you brush? _____How often do you floss? _____Would you like straighter teeth?____Would you like whiter teeth? _____

Check if you have had problems with the following:

Bad Breath	Grinding Teeth	Sensitivity to Hot	Clicking / Popping Jaw
Bleeding Gums	Sensitivity to Cold	Sensitivity When Biting	Loose / Broken Teeth
Periodontal Treatment	Sensitivity to Sweets	Sores or Growths in Mouth	Food Collection Between teeth

Medical History

Primary Care Physician? _____ Date of last visit? _____

Pharmacy:_____

Have you had surgeries or been hospitalized in the last 2 years?_____

Do you use caffeine & if so what? _____ Cups/Cans per day? _____

Do you use Tobacco & if so what? _____ Amount per day? _____

Are you currently pregnant? _____ Weeks:_____

Do you use recreational or street drugs? _____ Have you used street drugs with a needle? _____

Are you allergic to the following?

Aspirin	Penicillin	Codeine	Latex
Acrylic	Metal	Local Anesthetics	Other: _____

Do you have the following conditions? (Check or circle those that apply)

Allergies	Diabetes	High Blood Pressure	Sickle Cell Disease
Artificial Joints	Epilepsy/Seizures	Hepatitis A, B, C	Tuberculosis
Artificial Heart Valve	Excessive Thirst	Heart Pace Maker	Thyroid Problems
Asthma	Fainting / Dizziness	Kidney Problems	Ulcers
Angina	Frequent Cough	Liver Problems	Venereal Disease
Arthritis	Fever Blister / Cold Sores	Mental Disorders	Yellow Jaundice
Anemia	Glaucoma	Mitral Valve Prolapse	Congenital Heart Failure
Breathing Problems	Heart Infection	Osteoporosis	HIV / Aids
Cancer	Heart Surgery	Sinus Problems	Other: _____
Chemotherapy	Heart Murmur	Surgical Shunt	Other: _____
Chemical Dependency	Hay Fever	Stroke	Other: _____

Medications:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____**Date:** _____**Relationship to Patient:**_____

OFFICE POLICIES

We appreciate your confidence in selecting our practice for your dental care. If you have any questions about our services, fees or other aspects of your care with us, please feel free to discuss them with us.
This document is legally binding, so please read the following carefully and initial where specified and sign bottom of this sheet to indicate that you have read it, understand it, and accept its terms.

1.) Payment is Due at Time of Service (PATIENTS WITH MEDICAID INSURANCE)

For patients covered by **State insurance (Medicaid)**, Limited Medicaid covers preventative, diagnostic, dentures and anesthetic services copays may apply. Any other treatment has a maximum amount paid of $1125 annually. You have a choice of doing additional treatment at your own expense. Any charges that go over your max benefit of $1125 is your full responsibility! _____ (Intial)

2.) Payment is Due at Time of Service (PATIENTS WITH OTHER OR NO INSURANCE

We do expect full payment at the time of service. As a convenience, for patients covered by insurance, we bill the insurance company directly for all covered services. Patients are responsible for making sure we have all necessary insurance information and for any estimated portion as well as non-covered services at the time services are rendered. For patients who have no insurance, payment is to be made in full at the time services are rendered. *There is a $30.00 charge for any check returned unpaid to us from the bank in addition to the amount of the check.*

3.) Non-Covered Services

If for any reason a service provided to you is not covered by your insurance carrier, it will be your financial responsibility to pay for the service.

4.) Changes to Your Information

Please make sure that you update the staff with any changes in your employment, insurances, Medical, and contact information prior to receiving any service.

5.) Past Due Accounts

Balances older than 30 days past due will be charged 10% per annum interest.

6.) Outside Collections Accounts

If your account is referred to an outside company for collection, you agree to pay: a) our costs of collection; b) the total amount of the bill being referred; and c) a collection cost recovery fee ("CCR Fee") equal to **50%** of the total amount of the bill being referred. The CCR Fee shall be applied to recover the commission costs payable to any outside company for collection.

7.) Confirming appointments

You are required to verbally confirm each of your scheduled appointments. We agree to call you up to 48 hours before your appointment. If you do not verbally confirm your appointment there is a risk of it being pull from the schedule pending past missed appointments.

8.) No Show Appointments

For any appointments that you fail to attend or fail for notify us within 48 hours of your appointment time that you will not be attending, you agree to have a **$45.00** fee assessed to your account.

9.) We have the right to refuse service to anyone as well as dismiss them from our office

Our staff is happy to provide you with reasonable assistance in dealing with your insurance company or any other assistance you may require. Please note, however, that your participation in your insurance plan requires you to understand and abide by the terms governing your insurance plan. I authorize the release of any medical or other information reasonably necessary to process my insurance claims.

Patient or Legal Guardian Signature: _____**Date:**_____

Print Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Smile Montana Dental Center

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's notice of Privacy Practices

Patient Name: _____

Guardian Name: _____

Signature: _____Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign: _____

Communications barriers prohibited obtaining the acknowledgment: _____

An emergency situation prevented us from obtaining acknowledgement: _____

Other (Please Specify):_____

You May Refuse to Sign This Acknowledgment

I give Smile Montana Dental Center the permission to release the following information to the following person(s):

All account information: _____

Diagnosed Dental Treatment (only): _____

Financial information (only): _____

Name:_____Birth Date:_____Date:_____

Name:_____Birth Date:_____Date:_____

Name:_____Birth Date:_____Date:_____

Payment Agreement

For ALL Insured and Non-Insured patients

I understand that Smile Montana Dental Center is accepting me as a private payment patient and that I will be responsible for all services that are rendered to me. I understand that payment is due at the time of service and I will be responsible to pay for all services rendered.

As a courtesy, Smile Montana Dental Center will bill dental insurance once all necessary information is provided. If a dental insurance is billed, any non-covered services will be my responsibility and is due at the time of service.

This provider has the right to send my account to collections if the balance in not paid in a timely manner.

Name (Print): _____

Signature: _____

Date: _____