WELCOME !

Smile Montana Urgent Dental Center
115 Commons Way
Kalispell, MT 59901
406-314-6353

Patient Information:

Patients Name: _____ Social Security: _____ DOB: _____

Mailing Address:_____ ☐ Married ☐ Single ☐ Widowed

_____ ☐ Separated ☐ Divorced ☐ Minor Under 18

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

How did you hear about our office? _____

Pharmacy _____

Other immediate family member who have care here? _____

Responsible Party Information: (If patient is under 18)

Name: _____ Social Security: _____ DOB: _____

Mailing Address:_____ City, State, Zip: _____

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

Spouses Name: _____ Social Security: _____ DOB: _____

Mailing Address:_____ City, State, Zip: _____

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

Insurance Information:

Insurance Name: _____ Employer: _____ Group #: _____

Subscriber Name:_____ DOB: _____ Social Security #: _____Subscriber #: _____

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:** _____

Photography Release: **I do give my permission** ☐ **I do NOT give my permission** ☐

Patient: _____

I give permission for photographs of the person(s) listed below to be published on the following:

(Mark all that apply) Internet ☐ Website ☐ Facebook ☐ Office ☐ Photo Albums ☐

Patient Signature: _____ **Date:** _____

Guardian: _____ **Date:** _____

MEDICAL AND DENTAL HISTORY

Dental History:

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

Previous Dentist:_____ Date of last visit: _____

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? _____

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? _____

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

Are you currently pregnant? Yes _____ No_____ How many weeks?_____

Are you allergic to the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Latex
☐ Acrylic	☐ Metal	☐ Local Anesthetics	☐ Other: _____

Do you have the following conditions?

☐ 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	
☐ Chemical Dependency	☐ Hay Fever	☐ Stroke	

What medications do you currently take?

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

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 in full with a $3.00 copay. Any other treatment has a maximum amount paid of $1125 annually. You have a choice of doing additional treatment at your own expense.

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.

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)

HIPPA COMPLIANCE FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Smile Montana Urgent Dental Center

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's notice of Privacy Practices.
(Privacy Practices are laminated at the front desk for you to review. We can make a copy of them at your request.)

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)

_____

_____

_____