PATIENT INFORMATION

Name: _____ Date of Birth:_____ Age:_____
Address:_____ City:_____ State:__ Zip:_____
Social Security Number:_____ How did you hear about us?_____
Preferred Phone Number: _____ Is this a mobile phone? Yes ◯ No ◯

RESPONSIBLE PARTY

(only fill out if patient is a minor or has a legal guardian)

Name: _____ Date of Birth:_____ Age:_____
Address:_____ City:_____ State:__ Zip:_____
Social Security Number:_____ How did you hear about us?_____
Preferred Phone Number: _____ Is this a mobile phone? Yes ◯ No ◯
Relationship to Patient: Parent ◯ Other: _____

SIGNATURE: _____ DATE: _____

PREFERRED PHARMACY

Name: _____ Phone Number: _____
Address:_____ City:_____ State:__ Zip:_____

PRIMARY DENTAL INSURANCE

(please provide card to front desk if possible)

Insurance Name:_____ Group:_____ ID#: _____
Employer: _____ Phone Number: _____
Subscriber Name:_____ Subscriber Date of Birth:_____ Subscriber SSN:_____

SECONDARY DENTAL INSURANCE

(please provide card to front desk if possible)

Insurance Name:_____ Group:_____ ID#: _____
Employer: _____ Phone Number: _____
Subscriber Name:_____ Subscriber Date of Birth:_____ Subscriber SSN:_____

All insurances will be billed by our office as a complimentary service. Any fees that are not paid by the insurance company are the patient or guardian's responsibility. Payment is due at time of service and will be estimated according to the fee schedule and break down of benefits provided by your insurance company. Insurance estimates are not always 100% accurate, but we strive to ensure as little variation as possible based on the information we are provided.

PATIENT SIGNATURE: _____ DATE: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgment of receipt of HIPAA notice of privacy practice.

MONTANA DENTAL GROUP

270 HWY 2 E. Suite B
Columbia Falls, MT 59912

I, _____ hereby acknowledge that I have received and reviewed a copy of MONTANA DENTAL GROUP's HIPAA notice of privacy practices.

I understand that the HIPPA notice of privacy practices may change periodically and that I am entitled to a copy of the revised HIPPA notice of privacy practices upon request.

I understand that if I have questions about MONTANA DENTAL GROUP's privacy practices, I may contact the office at 406-578-8602.

I understand that it is my right to refuse to sign this form if I so choose and treatment will not be refused to me if I don't sign.

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 prevented us from obtaining acknowledgement
- Other (Please Specify):

DENTAL HISTORY

Reason for Visit:

◯ Check-up	◯ Cleaning	◯ Cosmetic	◯ Pain	◯ Cavities
◯ Loose Teeth	◯ Broken Teeth	◯ Gum Disease	◯ Bad Breath	◯ Grinding
◯ Clicking/popping Jaw	◯ Oral Sores	◯ Bleeding Gums	◯ Oral Growths	◯ Pressure
Sensitivity (select all that apply):	◯ Hot	◯ Cold	◯ Sweets	◯ Biting

◯ Other:_____

Do you require antibiotics prior to dental procedures? ◯ Yes ◯ No ◯ Unknown

Last Dental Visit: ◯ Last 6 months ◯ 6 months-1 year ◯ 1-3 years ◯ More than 4 years ◯ Never

Previous Provider and Office Name: _____

Provider Phone Number: _____ Provider City/State:_____

Date of Last Dental X -ray: ◯ Last 6 months ◯ 6 months-1 year ◯ 1-3 years ◯ More than 4 years ◯ Never

Do you currently wear Dentures? ◯Yes ◯No

Age of dentures: ◯ 6 months ◯ 6 months-1 year ◯ 1-3 years ◯ More than 4 years ◯ N/A

MEDICAL HISTORY

Are you under the care of a primary physician? ◯ Yes ◯ No

Primary Physician's Name: _____ Physician's Phone Number: _____

Are you currently pregnant, nursing, or attempting to become pregnant? ◯ Yes ◯ No

Have you been diagnosed with any of the following conditions? (check all that Apply)

◯ None	◯ Drug Addiction	◯ Non-dental Implant	◯ Alcoholism
◯ Epilepsy	◯ Allergies or Hives	Type: _____	◯ Excessive Bleeding
◯ Organ Transplants	◯ Anemia	◯ Fainting/Dizziness	◯ Arthritis
Type: _____	◯ Hearing Impairment	◯ Pacemaker	◯ Artificial Joint/Pins
◯ Heart Murmur	◯ Psychiatric Care	◯ Heart Surgery	Type: _____
◯ Radiation Therapy	◯ Radiosurgery	Date: _____	Age: _____
◯ Rheumatic Fever	◯ Seizures	◯ Heart Trouble	◯ Aspirin Therapy
◯ Asthma	◯ Blood Thinners	◯ Blood Transfusion	◯ STD/STI
◯ High Blood Pressure	◯ Sinus Problems	◯ Breathing Problems	◯ HIV
◯ Stomach Problems	◯ Cancer	◯ Kidney Disease	◯ Stroke
◯ Thyroid Disease	Type: _____	◯ Chemotherapy	◯ Liver Disease
◯ Low Blood Pressure	◯ Tuberculosis (TB)	◯ Coumadin Therapy	◯ Lung Disease/COPD
◯ Ulcers	◯ Dementia	◯ Lupus	◯ Visual Impairment
◯ Diabetes	◯ Mitral Valve Prolapse	◯ Dialysis	◯ Mobility Impairment

Are you allergic or have you had an adverse reaction to any of the following?

◯ Amoxicillin ◯ Aspirin ◯ Codeine ◯ Epinephrine ◯ Latex ◯ Metals ◯ Novocain ◯ Penicillin ◯ Sulfa

◯ Tetracycline ◯ Other: _____

_____

List any medications you are taking including non-prescription or recreational drugs and herbal or vitamin supplements:

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

MONTANA DENTAL GROUP
OFFICE POLICIES

Montana Dental Group takes pride in providing high quality dental care for all our patients. When we schedule your appointment, we do so in a way that we can spend quality time with you. It is a priority to us to make sure that we are prompt for you scheduled appointment time and ask the same courtesy of you.

Montana Dental Group reserves the right to refuse service to anyone for any legal reason.

Appointments must be confirmed by either text or phone. If an appointment is not confirmed prior to the appointment date and you or a family member has broken appointments previously, we reserve the right to cancel your appointment and reschedule.

Our office requires that if an appointment must be cancelled that we are given a 24-hour notice. We do understand last minute emergencies and unforeseen circumstances occur but, we ask that you try your best to make sure we are given the required notice.

Appointments that are canceled without a 24-hour notice or that are a no show may be charged a **$45 per hour** fee for that appointment. This fee will not be covered by insurance and must be paid in full before a new appointment can be scheduled.

You can reach our voicemail or send a text at 406-578-8604 24 hours a day.

If a patient misses more than **one appointment**, we reserve the right to dismiss you from our practice and discontinue your treatment at our office. We will release your records to a new provider with a signed records release form should this happen.

We do require payment in full at the time of service, we do not do payment plans in our office making the patient financially responsible for any charges that are incurred and not covered by insurance.

If a patient fails to pay for their services, the balance will be turned over to a collection's bureau. If your account goes to collection you will be charged an additional **$65 collections fee** and any applicable attorney fees, or court costs associated with the account.

Our office will first text then call if the text does not receive a response to confirm appointments.
If you would like to opt out of texting please initial. _____

Treatment plans and cost estimates will be provided upon request and are valid for 60 days from their printed date.

I acknowledge that I have read, understand, and accept the above office policies

SIGNATURE: _____ DATE: _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the Office today because you a dental condition Which must be treated at this time and cannot be postponed until all COVID-19 restrictions are lifted. Please be advised of the following:

> While our office complies with State Health Department the Center for Disease Control and Prevention infection control guidelines to minimize the spread of COVID-19 Virus, we cannot make any guarantees.
>
> Our Staff are symptom-free and to the best of their knowledge have not been exposed to the Virus. However, since we are a place of public accommodation, other persons (including other patients and those who may accompany them) could be infected with or without their knowledge.

In order to reduce risk of COVID-19, we are asking you to fill out the lower section of this form truthfully to the best of your ability for the safety of our staff and all our patients.

PLEASE INDICATE YOUR ANSWER BY INITIALING IN THE RELEVANT BOX

	YES	NO
Do you have a fever?		
Are you encountering shortness of breath?		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Within the last 14 days, have you traveled out of Montana?		

Where? _____

By signing you certify that all statements made are as truthful as possible.

SIGNATURE: _____ DATE: _____