

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.



Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

Y N Bad breath Y N Food collection between teeth Y N Periodontal treatment Y N Sensitivity to sweets

Y N Bleeding gums Y N Grinding or clenching teeth Y N Sensitivity to cold Y N Sensitivity when biting

Y N Clicking or popping jaw Y N Loose teeth or broken fillings Y N Sensitivity to hot Y N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Address _____ Email _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Skin rash
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	Describe _____	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease
<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis		
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments			

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 20__.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

BOZEMAN DENTAL ASSOCIATES

Dean C. Mortenson

2018 Stadium Drive

Bozeman, Montana 59715

**BOZEMAN DENTAL ASSOCIATES
2018 STADIUM DRIVE
BOZEMAN, MT 59715
(406) 586-9621**

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Patient _____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment at the time services are rendered. We accept MasterCard, Visa, American Express, and Discover credit cards. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

LATE CHARGES: If I do not pay the entire balance within 60 days of the monthly billing date, a finance charge of 1.25% on the past due balance will be assessed each month. I realize that failure to keep the account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the event legal action should become necessary to collect any unpaid balance for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. If my past due account is referred for outside collection, I agree to pay all collection costs, all attorney fees and all court costs. All returned checks may be assessed a fee of \$30.

Thank you for completing these forms. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have questions at any time, please feel free to ask us. We are always happy to help.

Signature of Patient, Parent or Guardian if a Minor

Date