Medical Consultation for Montana City Dental, PC

Sent to: ______________________________ Date Sent: ______________

Please complete the information below and return this form to Montana City Dental, PC.

Montana City Dental, PC
2 Market Street
Clancy. MT 59634
Phone: 406-443-5130
Fax: 406-443-5131

Patient Name: ____ Date of Birth: _____________________

Medical Condition/Procedure:

Are there any contraindications to routine dental treatment using local anesthetic with epinephrine (routine treatment includes but is not limited to fillings, extractions, root canals, deep cleanings)?

Yes _____ No _____

If yes, please comment:

Is antibiotic prophylaxis required?

Yes _____ No _____ If yes, for how long? ____

Is there a waiting period prior to having dental treatment?

Yes _____ No _____ If yes, for how long? ____

____________________________	____________________________	________	__________________
Medical Provider Name, please print	Medical Provider Signature	Date	Phone Number

Patient Information

Patient Name ______________________________

Date ______________________________

SS# ______________________________

Address ______________________________

____

Email ______________________________

Sex M___ F___ Birthdate ______________

Married ___ Partnered ___ Single ___ Minor ___

Spouse's/Partner's name ______________________

Your Occupation ______________________

Employer/School ______________________

Employer/School Address ______________________

____

Previous Dentist ______________________

Any Dental Concerns ______________________

Whom may we thank for referring you:

____

Dental Insurance

Who is Responsible for Account:

____

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Assignment and Release

I assign insurance benefits for services rendered to Montana City Dental, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Montana City Dental, PC may use my health care information for the purpose of obtaining payment for services and facilitating dental treatment with other health care professionals.

____

Signature of patient, guardian, or personal representative

____

print name of patient, guardian, or personal representative

Phone Numbers

Home ______________ Work ______________ Cell ______________

In Case of an Emergency Contact:

Name ______________________ Relationship ______________________

Phone Numbers ______________________________

Patient Name ______________________ Patient Date of Birth ______________________

Health History

Physician Name and Phone Number ____

Have you ever had orthopedic total joint (hip, knee, elbow, finger, etc) replacement? **Yes** ___ **No** ___

Are you taking, scheduled to take, or ever taken Alendronate (Fosamax), Risedronate (Actonel), intravenous Bisphosphonates (Aredia or Zometa) for osteoporosis, bone repair, or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastatic cancer? **Yes** ___ **No** ___

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes ___	No ___	Epilepsy	Yes ___	No ___	Radiation Treatment	Yes ___	No ___
Anemia	Yes ___	No ___	Fainting or dizziness	Yes ___	No ___	Respiratory Disease	Yes ___	No ___
Arthritis	Yes ___	No ___	Glaucoma	Yes ___	No ___	Rheumatic Fever	Yes ___	No ___
Artificial Heart Valve s	Yes ___	No ___	Head Aches	Yes ___	No ___	Scarlet Fever	Yes ___	No ___
Artificial Joints	Yes ___	No ___	Heart Murmur	Yes ___	No ___	Shortness of Breath	Yes ___	No ___
Asthma	Yes ___	No ___	Heart Problems	Yes ___	No ___	Sinus Trouble	Yes ___	No ___
Back Problems	Yes ___	No ___	Hepatitis Type ____	Yes ___	No ___	Skin Rash	Yes ___	No ___
Bleeding Abnormally	Yes ___	No ___	Herpes	Yes ___	No ___	Special Diet	Yes ___	No ___
Blood Disease	Yes ___	No ___	High Blood Pressure	Yes ___	No ___	Stroke	Yes ___	No ___
Cancer	Yes ___	No ___	Jaundice	Yes ___	No ___	Swollen Feet/Ankles	Yes ___	No ___
Chemical Dependency	Yes ___	No ___	Jaw Pain	Yes ___	No ___	Swollen Neck Glands	Yes ___	No ___
Chemotherapy	Yes ___	No ___	Kidney Disease	Yes ___	No ___	Thyroid Problems	Yes ___	No ___
Circulatory Problems	Yes ___	No ___	Liver Disease	Yes ___	No ___	Tobacco	Yes ___	No ___
Congenital Heart Lesions	Yes ___	No ___	Low Blood Pressure	Yes ___	No ___	Tonsillitis	Yes ___	No ___
Cortisone Treatments	Yes ___	No ___	Mitral Valve Prolapse	Yes ___	No ___	Tuberculosis	Yes ___	No ___
Cough, persistent/bloody	Yes ___	No ___	Nervous Problem	Yes ___	No ___	Tumor	Yes ___	No ___
Diabetes	Yes ___	No ___	Pacemaker	Yes ___	No ___	Ulcer	Yes ___	No ___
Emphysema	Yes ___	No ___	Psychiatric Treatment	Yes ___	No ___	Unexplained Weight Loss	Yes ___	No ___

Women:

Are You Pregnant Yes ___ No ___ Taking Birth Control Pills Yes ___ No ___ Nursing Yes ___ No ___

Date Due ______________

Medications

Are you currently taking any medications or Herbal preparations? Yes ___ No ___

If so, please list on the **Medications Form.**

Allergies

___ Aspirin
___ Codeine
___ Latex
___ Local Anesthetic
___ Penicillin
___ Sulfa
___ Other: ______________
____

Patient/Guardian's Signature ______________________ Date ____________

Dentist's Notes ____

____

____

Medication Form

Print Name   Signature   Date

Medications	Dose	Reason for Taking	Doctor Name

MONTANA CITY DENTAL CLINIC, P.C.

(406) 443-5130

APPOINTMENT CANCELLATION POLICY

We understand that you may need to reschedule or cancel your future appointments. Breaking an appointment without appropriate notice hinders our ability to care for you as well as others. With advance notice we are able to use that time slot to help others.

If for any reason, you need to reschedule or cancel an appointment we require at least **24 hour notce**. You may call our office at any time. Please leave a message if we are not available. If we do not receive 24 hour notice, we reserve the right to assess a "**No Show Fee".**

We appreciate your understanding in this matter. Please continue to help us care for our patients in a consistent and timely manner.

____

Signature

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ____, have reviewed a copy of this Office's Notice of Privacy Practices.

____DATE:______________

Signature

Montana City Dental, PC
Payment Policy

Patients with Dental Insurance

If a patient has dental insurance, we will file a claim when services are rendered. We typically receive payment within 2-4 weeks. We will bill the patient for the remaining balance. If a claim is denied or there is no response from the insurance company, it is the patient's responsibility to pay the full balance to Montana City Dental, PC.

Cash Paying Patients

Payment in full is required at the time of service. If paying by cash or check, patients will receive a 10% discount. We also accept credit card payment.

Lab Work

One half of the fee for any procedure requiring lab work must be paid by the patient on the first day of treatment. Lab work includes, but is not limited to crowns, implant crowns, bridges, full dentures, and partial dentures. The fee for night guards must be paid in full at the time of treatment.

Past Due Accounts

Our office will contact a patient by phone or mail if payment on an account is 90 days past due. It is the patient's responsibility to pay the balance of this account in full. If the payment is not received within 14 days after the 90 day past due notice was sent the account will be sent to collections. All patients on an account that has been sent to collections will have future appointments canceled and will not be scheduled for any more appointments in our office.

I, the undersigned, have read and agree to Montana City Dental, PC's payment policy.

______________________________	____________________________	___________
Patient Name (please print)	Patient Signature	Date