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

Required Insurance Information

Subscriber's Name (If not patient, provide name and date of birth):

Subscriber ID #:

Group #:

Group (Employer) Name:

Claims Mailing Address:

Payor ID#:

Customer Service Phone #: