Montana Family Dentistry

PATIENT INFORMATON

Patient's Name:_____ Preferred Name:_____

Address:_____ City, State:_____

Home Phone:_____ Cell Phone:_____ SSN#:_____

Gender:_____ DOB:_____ How did you hear about us:_____

Email address:_____

I would like to receive correspondences via email: yes___ no___

Emergency Contact:_____ Phone :_____

Family Physician:_____ Phone:_____

Responsible Party Information: -Please fill in even if same as above and complete **ALL** sections

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____ City, State:_____

Mailing Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

DOB:_____ SSN:_____

Relationship to Patient:_____

Employer:_____ Phone: _____

Address:_____ City, State:_____

Insurance Information Primary: - Please complete **ALL** sections

Name of Insurance Company:_____ Policy Number:_____

Claims Address:_____ City, State, Zip:_____

Policy Holders Name:_____Address:_____

SSN:_____ Relationship to Patient:_____

Employer:_____

AUTHORIZATION: (PLEASE INITIAL AND SIGN BELOW)

_____ I have answered all of the previous questions to the best of my knowledge and understand the dentist will use this information to determine appropriate treatment for myself or my children. I agree to notify the dentist of any changes in mine or my children's health status immediately.

_____ I hereby authorize the Doctor's and staff of Montana Family Dentistry to provide dental treatment for myself, or child (if patient is a minor). I consent to such treatment, medications, and treatment methods as a deemed appropriate by the doctors and staff in providing the safest and best possible dental care for me or my child.

_____ I hereby authorize Montana Family Dentistry to release all information necessary to secure payment of benefits and authorize my insurance company to pay the benefits otherwise payable to me. I also authorize the use of my signature on all insurance claim submissions.

_____ I understand that I am responsible for payment of all services provided and that the office bills insurance companies as a courtesy. I also understand I am responsible to pay for the services 100% of any services deemed by the dentist's office to be non-covered by insurance. I understand that this is not a guarantee that the insurance will pay the balances of services. In the event the insurance does not pay the estimated balance in full, I understand that I will be billed for the difference.

_____ **I understand that if no insurance provided, balance must be paid in full at the time of service. If payment cannot be made in full, I understand that I must sign a payment plan contract with the financial director.** I understand that if contract is broken, collection actions will be taken. I understand that if collection actions are taken, I will be responsible for all fees involved with the process including, but not limited to: interest, legal fees, court fees, and processor fees.

Responsible Party's Signature: _____Date:_____