MONTANA ROOTS DENTAL CARE

PATIENT INFORMATION

Patient (Legal) Name: _____(PreferredName)_____

Email Address: _____Previous/Maiden Name(s):_____

Social Security #: _____Birth Date: _____ Male: ☐ Female: ☐

Mailing Address: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Preferred Contact Method: Text: ☐ Call : ☐ Email ☐

Spouse Name: _____Phone: _____Spouse Social Security #: _____

Spouse Birth Date: _____ Spouse Employer: _____Spouse Work phone #: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Mother's Name: _____Father's Name: _____

Mother's Social Security #: _____DOB:_____ Father's Social Security #: _____DOB:_____

Address: _____

FINANCIAL/HEALTH DISCLOSURE MATTERS

If you would like us to discuss your health or billing information with someone else, such as a parent or personal representative, please provide us with their contact information.

Name of Contact: _____

Phone Number: _____

Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____Phone #: _____

ABOUT YOUR INSURANCE – We will need a copy of all insurance cards

Primary Insurance: _____ Secondary Insurance (if applicable): _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IMPORTANT INFORMATION (PLEASE READ)

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

I grant authority to the Dentist to perform procedures and treatments, including administration of medication, along with other surgical and dental procedures that may be necessary.

I have been offered access to the HIPAA regulation notice of privacy practices that are in place at Montana Roots Dental Care.
I understand that **all appointments cancelled with less than 24 hour notice** are subject to a missed appointment fee.
I have read and understand the financial policy and that balances left unpaid over 90 days may be subject to a finance charge.

PATIENT OR GUARDIAN SIGNATURE:_____DATE: _____