MONTANA ROOTS DENTAL CARE

PATIENT INFORMATION

Patient (Legal) Name: _____(PreferredName)_____Pronouns: _____

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

Social Security #: _____ Birth Date: _____ Male: ☐ Female: ☐ Gender Identity: _____

Mailing Address: _____ Zip Code_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Preferred Contact Method: Text: ☐ Call : ☐ Email ☐ (By choosing Text/Email I am agreeing to receive electronic communications from MRDC)

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: _____

Please Note: The Parent or Legal Guardian that Consents to treatment of a minor is financially responsible for any remaining balances after insurance payment!!

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. 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:** _____

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. Initial _____

I understand that **all appointments cancelled with less than 24 hour notice** are subject to a missed appointment fee of $56.00. Initial _____

Deposits Due on Date of Service are: $400 for crowns or implants, $150 for root canals, $25 per filling for general fillings, and $125 for extractions. Any over-payments will be promptly refunded directly to patient. Initial _____

We offer a 5% Courtesy Discount for check payment in full the date of service only for those without dental insurance. Initial _____

PATIENT OR GUARDIAN SIGNATURE:_____**DATE:** _____