Belgrade Dental Associates – Patient Information

We are pleased to "Welcome You" to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PERSONAL INFORMATION

Name: ____
Last First M.I.

Sex: M F Married: Y N Spouse: ______________________

Date of Birth: ______________________ SS#: ______________________

**If Patient is a Minor, please give parents or guardian's name and initial for permission to treat the minor.

______________________________________ ________
Name Initials

Address: ______________________________________

City: ______________ State: __________ Zip: __________ **For Appt Notification**

Phone: H: ____________ Work: ____________ C: ____________ **Text: Y N**

Email address: ______________________ Best time to call: ______________

Place of Employment: ______________________________________

Full Time: □ Part Time: □ Retired: □ Not Employed: □ Student: □

Person responsible for account:

Self □ Other □: ______________________ SS#: ______________

How did you hear about our office?

From Another Patient □ Name: ______________ Other □ ______________

Phone Book: DEX □ Which ad?:______________ **Bozeman Local Book** □ **Radio Ad:** ______________

Primary Emergency Information:

Name: ______________________

Street: ______________________

City: ____________ State: _____ Zip: _________

Phone: ______________________

Secondary Emergency Information:

Name: ______________________

Street: ______________________

City: ____________ State: _____ Zip: _________

Phone: ______________________

Previous Dentist Information:

Name: ______________________

Street: ______________________

City: ____________ State: _____ Zip: _________

Phone: ______________________

X-ray's Taken? Yes No

NOTE: We are happy to fill out the forms for you as a courtesy and file your forms electronically to your benefit company. We ask ALL of our patients, regardless of benefit coverage, to pay in full on the day of service. We accept: cash, check, all major credit cards and we also have available low or no interest financing OAC, to work within your budget.

Signature of Patient, Parent or Guardian Date

MEDICAL HISTORY

Name of Medical Doctor/(OBGYN if applicable:____

Street: ________________________________ City: _________________ Zip: __________

Emergency Contact: ________________________________ Phone: ____________________

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take you time and answer each question as completely and honestly as possible. Please sign each page.

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING CONDITIONS (please mark all that apply):

Medical Condition	Never	Current	Past		Never	Current	Past		Never	Current	Past
Acid Reflux				Emphysema				Neuralgia			
AIDS/HIV Positive				Epilepsy or Seizures				Osteoarthritis			
Alzheimer's Disease				Excessive Thirst				Osteoporosis			
Anaphylaxis				Fibromyalgia				Pain in Jaw Joints			
Anemia				Frequent Headaches				Parathyroid Disease			
Angina				Frequent Cough				Prior Orthodontic Treatment			
Arteriosclerosis				Frequent Diarrhea				Psychiatric Care			
Arthritis				Genital Herpes				Radiation Treatments			
Artificial Heart Valve**				Glaucoma				Recent Weight Loss			
Artificial Joint**				Gout				Renal Dialysis			
Asthma				Hay Fever				Rheumatic Fever**			
Autoimmune Disorder				Heart Attack/Failure				Rheumatism			
Bleeding Easily				Heart Murmur**				Scarlet Fever			
Blood Disease				Heart Pace Maker**				Sinus Problems			
Blood Transfusion				Heart Valve Replacement				Shingles			
Breathing Problems				Heart Disorder				Sickle Cell Disease			
Bruise Easily				Hemophilia				Sleep Apnea			
Cancer				Hepatitis A				Sleep Problems			
Chemotherapy				Hepatitis B or C (please circle)				Spina Bifida			
Chest Pains				Herpes				Spinal Viral Menegitis			
Chronic Fatigue				Hiatal Hernia				Stomach/Intestinal			
Chronic Pain				High Blood Pressure				Stroke			
COPD				Hives or Rash				Swelling of Limbs			
Cold Sores/Fever Blisters				Hypoglycemia				Tendency- Ear Infections			
Congenital Heart Disorder				Insomnia				Thyroid Disease			
Convulsions				Immune System Disorder				Tonsillitis			
Cortisone Medicine				Irregular Heartbeat				Tuberculosis			
Current Pregnancy				Kidney Problems				Tumors or Growths			
Depression				Liver Disease				Tobacco User			
Diabetes (Type I or II)				Low Blood Pressure				Ulcers			
Diabetic Neuropathy				Lung Disease				Urinary Disorders			
Difficulty Sleeping				Meniere's Disease				Venereal Disease			
Disphasia				Mitral Valve Prolapsed**				Yellow Jaundice			
Dizziness/ Fainting Spells				Multiple Sclerosis				Other-			
Drug Addiction				Muscular Dystrophy				**Conditions may require a Pre-Medication			
Easily Winded				Nasal Allergies							

Signature of Patient, Parent or Guardian Date

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

☐ Antibiotics	☐ Iodine	☐ Penicillin	☐ Sulfa Drugs
☐ Aspirin	☐ Latex	☐ Plastic	☐ NO KNOWN ALLERGIES
☐ Barbiturates	☐ Local Anesthetics	☐ Sedatives	
☐ Codeine	☐ Metals	☐ Sleeping Pills	

LIST ANY TYPE OF Non-Selective BETA BLOCKER BEING TAKEN: **LIST ANY TYPE OF BISPHOSPHONATES BEING TAKEN:**

☐ Alprenolol	☐ Labetalol	☐ Pindolol		☐ Alendronate	☐ Fosamax
☐ Bucindolol	☐ Nadolol	☐ Propranolol		☐ Ibandronate	☐ Boniva
☐ Carteolol	☐ Oxprenolol	☐ Sotalol		☐ Risedronate	☐ Actonel, Atelvia
☐ Carvedilol	☐ Penbutolol	☐ Timolol		☐ Zoledronic acid	☐ Reclast / IV

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication Name	Dosage/Frequency	Reason

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

☐ Appendectomy	☐ Heart	☐ Thyroid	☐ Hip Replacement Date: Dr:
☐ Back	☐ Hernia Repair	☐ Tonsillectomy	☐ Knee Replacement Date: Dr:
☐ Ear	☐ Lung	☐ Uvulectomy	☐ Heart Valve Replacement Date: Dr.
☐ Gallbladder	☐ Nasal	☐ Periodontal	☐ Other Joint Replacement Date: Dr.

FAMILY HISTORY: Has any member of your family had: (parent, sibling or grandparent)

	Yes	No		Yes	No		Yes	No
Cancer			Stroke			Father Snores		
Heart Disease			Sleep Disorder			Mother Snores		
Diabetes			Obesity			Father has Sleep Apnea		
High Blood Pressure			Thyroid Disorder			Mother Has Sleep Apnea		

SOCIAL HISTORY:

	Never	Past	Currently	Type	How Much/Weekly
Tobacco Use					
Alcohol Use					
Caffeine Intake					
Exercise					

Comments:____

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I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage. I certify that the questions and medical history on this form are complete and accurate. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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Signature of Patient, Parent or Guardian Date

Belgrade Dental Associates Payment Policy

We are pleased you have entrusted us to provide your dental care. We strive to provide quality care in a relaxed environment, however, running a small town business with reasonable fees requires timely collection of accounts.
Thank you in advance for helping us to keep our costs down, by adhering to our payment policy.

When is payment expected?

If you are covered by insurance, we require your co-payment the day of service.
If you are not insured, payment is due the day of service.
Emergency and After Hours appointments require payment in full at the time of service.
Charges for initial (1st Time) appointments are due at the time of service. If you have insurance coverage, the co-payment is acceptable the day of service.

Payment Options?

For patients that need financing options we accept Care Credit and Lending Club. Both of these third party financiers offer No Interest or Extended Payment Plans to qualified applicants. Please ask in advance if you are interested in applying for these.
We Gladly accept, Cash, Check, Visa, MasterCard, American Express & Discover.

Dental Insurance Policy

Dental Insurance is a contract between the patient and the insurance company. You the patient are ultimately responsible for the charges you incurred in our office. As a service to you, we will be happy to submit a claim to your insurance carrier for you treatment. We ask that you provide us with the correct and/or updated insurance information. We are not responsible for fee limitations set by your insurance company or delays in their handling of your claim. Some insurance programs provide little or no coverage and very few pay the entire amount. Please familiarize yourself with your insurance policies, deductibles, co-payments and limitations. Our services are offered on the understanding that you are financially responsible for the total amount of your account. Due to the volume of claims processed through our office each day it is impossible to track the status of each claim, for each patient. Once the claim has been processed through our office we ask that you manage your claim. Of course, if additional information is needed or resubmission is necessary we will gladly do that for you.
I understand the Payment Policy, and realize that I am financially responsible for all charges incurred by myself, spouse and my minor children for treatment provided. Should my account be referred to an outside collection agency, I will be responsible for all collection costs, all attorney fees and all court costs.

Signature of Patient, Parent or Guardian Date

Health Insurance Portability and Accountability Act of 1996

(Federal Medical/Dental Requirement)

Acknowledgement of Receipt

I acknowledge that I have received a copy of Belgrade Dental Associates Notice of Privacy Practices. All special instructions must be submitted to Belgrade Dental Associates in writing.

Print Patient Name: ____

Patient Signature: ____

Date: ______________________

Patient Authorization for Release of Records and X-Rays

Belgrade Dental Associates
412 W Main, Suite 1
Belgrade, MT 59714
406.388.8006

Purpose of Release:

- ☐ Co-Diagnosis / Second Opinion
- ☐ Transfer from ***Belgrade Dental Associates*** to another Practice
- ☐ Transfer from another Practice to ***Belgrade Dental Associates***

Patients Name(s): ____

Address: ____

Phone Number(s): ____

I authorize the professional office of: _____________________________________ to release all radiographs and/or records to the below named practice or the patient. The above named patient, in requesting a records transfer, releases ***Belgrade Dental Associates*** of any legal liability in regards to the confidentiality of transferred information.

Transfer Office (If self, please write your name or the name of the person picking up the information):

Practice Name: ____

Full Address: ____

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I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: ____

Date: ____