Stonehorse Dental Clinic

Welcome! Thank you for selecting our dental health care team. We will strive to offer you the best quality care in a compassionate environment.

Patient Information (Confidential)

Last Name_____ First Name_____

Middle Name_____ Prefix_____ Preferred Name _____

Date of Birth _____ Social Security No. _____

__Minor __Single __Married __Divorced __Widowed Gender: __Male __Female Occupation: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Whom may we thank for referring you _____

Responsible Party

____Same as patient

Name of Person Responsible for this account _____ Gender: ___Male ___Female

Date of Birth _____ Social Security No. _____

Relationship to Patient _____ Is this person a patient in our office? _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Insurance Subscriber Information

Name of subscriber _____ Gender ___Male ___Female

Insurance company _____ Group # _____

Policy # _____ Subscriber's Social Security No. _____

Subscriber's Date of Birth _____ Employer Name _____ Phone _____

Patient's Relationship to subscriber: __Self __Spouse __Child/Stepchild

Secondary Insurance: If you have coverage from multiple insurance plans please advise us and present cards for photocopies.

Name of subscriber _____ Gender ___Male ___Female

Insurance company _____ Group # _____

Policy # _____ Subscriber's Social Security No. _____

Subscriber's Date of Birth _____ Employer Name _____ Phone _____

Patient's Relationship to subscriber: __Self __Spouse __Child/Stepchild

The information on this page is correct to the best of my knowledge. I authorize the dentist to release any information including diagnosis and the records of treatment and examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company pay directly to this dental office. I understand that my dental insurance may pay less than the actual cost of care and agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if I am delinquent on my account I am responsible for any finance charges that may be assessed and should I default on payment of my account and collection agency services are required all cost of collection including attorney fees will be added to the balance of my account.

Signature of Patient (or guardian) _____ Date _____

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Medical and Dental History

Patient Name _____DOB_____ Height _____ Weight _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Preferred Pharmacy: _____

Medical History

Physician _____ Phone _____ Last Visit _____

__Yes __No Are you under a physician's care now? If yes, why? _____

Physicians Name _____ Phone _____

__ Yes __ No Have you ever been hospitalized or had a major operation? What? _____

__ Yes __ No Are you taking any medications? Please list _____

_____

_____

__Yes __ No Are you allergic to any medications or substances?

__ Acrylic __Aspirin __Codeine __ Latex __ Local Anesthetic __ Metal __ Penicillin __ other _____

Do you have now, or have you ever had any of the following?

__Yes __ No Arthritis	__ Yes __ No Epilepsy/Seizures	__ Yes __ No Kidney Disease
__Yes __ No Artificial Heart Valve	__Yes __ No Tobacco use	__Yes __ No Mitral Valve Prolapse
__Yes __ No Artificial Joint	__Yes __ No Heart Murmur	__Yes __ No Pacemaker
__Yes __ No Asthma	__Yes __ No Heart Surgery	__Yes __ No Radiation/Chemo
__Yes __ No Bone Density Meds. Use	__Yes __ No Heart Trouble	__Yes __No Marijuana Use
__Yes __ No Cancer	__Yes __ No Hepatitis _A _B _C	__Yes __ No Stroke
__Yes __ No Diabetes	__Yes __ No High Blood Pressure	__Yes __ No Thyroid Problems
__Yes __ No Endocarditis	__Yes __ No HIV/AIDS/Herpes	__Yes __ No Tuberculosis

__Yes __ No Have you ever had any other serious illness or conditions not listed? _____

_____

Women are you: __Pregnant If Pregnant, due date: _____ ___Nursing ___Taking Birth Control

Dental History

Previous Dentist _____Date of Last Visit _____

Primary Reason for today's appointment _____

__Yes __ No Have you had problems with previous dental treatment?	__Yes __ No Are you satisfied with the appearance of your teeth?
__Yes __ No Are you apprehensive about dental care?	__Yes __ No Do you clench or grind your teeth?
__Yes __ No Do your gums bleed when brushing or flossing?	__Yes __ No Do you experience jaw pain or joint clicking?
__Yes __ No Have ever had a night guard /sleep appliance?	__Yes __ No Have you had orthodontic treatment?
__Yes __ No Have you noticed sores in your mouth?	__Yes __ No Have you ever been treated for gum disease?
__Yes __ No Are your teeth sensitive to hot, cold or sweets?	__Yes __ No Have you had any head, neck or jaw injuries?
__Yes __ No Do you have dental implants?	__Yes __ No Have you had excessive bleeding after extractions?

To the best of my knowledge all the preceding answers are correct. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health status or medication, I shall inform the dentist and staff at the next appointment.

Signature of Patient (or guardian) _____ Date _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)
*Obtaining payment from third party payers (e.g. my insurance company)
*The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date_____
Print Patient(s) Name_____
Signature _____
Relationship to Patient(s) _____

Stonehorse Dental Clinic
39821 Stone Horse Drive
Polson, MT 59860
406-872-2299

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PATIENT PAYMENT AGREEMENT

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and understanding of our payment policy. We offer the following methods of payment of fees:

A. **Payment in full is due at the time of service**. We cannot grant exemptions. We offer a 5% discount for accounts paid in full at time of service with cash or check. Insurance, credit and debit card transactions are ineligible for this discount.
B. As a courtesy to our patients we will file your insurance. It is the responsibility of the patient to know the limits of your insurance. We cannot guarantee what your insurance will pay. We will estimate as closely as possible what your out of pocket expenses will be. **You will be expected to make payment at the time of service for any deductibles or co-payments for your treatment.** If insurance claims take over 60 days to be paid by the insurance company, we ask that the patient pay the balance in full and once the insurance pays the claim we will issue a refund if there is one coming to the patient.
C. We also offer interest free or extended payment plans through **CareCredit** dental financing (O.A.C.). You may apply by going to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.
D. In case of divorce or separation, **the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

PAYMENT AGREEMENT:

I, _____, authorize treatment for myself or minor, and agree to pay all fees and charges for such treatment. I understand that I am responsible for payment of any unpaid balance **due** from my insurance company, **within 60 days** of treatment. I understand that overdue accounts will be sent to a collections agency and I authorize release of protected information for collections purposes. I also agree to pay an interest penalty of 1.5% per month on any outstanding balance over 60 days. There will be a service charge on all returned checks. I acknowledge receipt of a copy of this agreement.

Patient or Responsible Party_____Date_____

Stonehorse Dental Clinic

OFFICE NO SHOW POLICY

PLEASE READ CAREFULLY

In order to provide you and /or your child with the best care possible, we recommend you to make scheduled appointments and we ask that you make every effort to keep that appointment and arrive in a timely manner. To have an efficient office, to keep health care costs down, and to pay employees for their valued training we have had to implement a NO SHOW POLICY.

If a patient is more than 10 minutes late, we will not be able to see them, and this will be considered a No Show.

On the SECOND NO SHOW, patients will be charged a $25 missed appointment fee.

On the THIRD NO SHOW, patients will be dismissed from further scheduled appointments.

Upon dismissal we will provide emergency care for 30 days, at which time we will forward any records we have on file to the dentist of your choice.

If you need to reschedule or cancel an appointment, we require a minimum of 24 hours' notice. Monday appointments must be cancelled by the Friday before your appointment. Please call our office at 406-872-2299 to cancel or reschedule appointments. If proper notice is not given, this will be considered a NO SHOW.

We realize that on rare occasions, emergencies will arise, and we will address these situations with you on a case-by-case basis.

We thank you for working with us to ensure services are provided to you and your family in the best possible way so all can achieve their goals for optimal dental health.

**We reserve the right to charge $25 for missed appointments. **

Acknowledgement of No Show Policy:

Patient Name(s) _____

Signature of Patient or Guardian _____ Date _____

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Patient Photo Release Form

I _____, hereby authorize Stonehorse Dental Clinic or any of their assignees to take photographs, slides and videos of my teeth, jaws and face. I understand that the photographs, slides and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, Instagram posts, etc.)

I further understand that if the photographs, slides and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. *If I wish to revoke this consent, I may do so in writing by contacting the address above.*

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my TEETH shown without any identifying features.

_____I DO NOT want my photographs to be taken or used in any of the above stated situations.

_____	_____
Signature	Parent/Guardian Signature (If underage of 18)
_____	_____
Printed Name	Parent/Guardian Printed Name (If underage of 18)
_____	_____
Date	Date