**PATIENT ACQUAINTANCE FORM**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First MI**

Date of Birth: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street City State Zip Code

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who May We Thank for Your Referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**DENTAL INSURANCE:**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber SSN/ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Secondary Insurance Company Information (if applicable)*

List Policy Holder Name, Insurance Co. Address, Telephone, Policy No, Group No.:

**CONSENT FOR TREATMENT**

1. I hereby authorize the Doctor or designated Staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient’s dental needs.

2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of an anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I authorize my insurance benefits to be paid directly to the Doctor. I agree to be responsible of payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand in the event payments are not received by agreed upon dates, the balance including any late fees may be added to my account.

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby give my consent for Montana Dental Works (3 Sunset Plaza, Kalispell, MT.) to use and disclose protected health information about me to carry out dental treatment and payment. The Notice of Privacy Practices provided by Montana Dental Works describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Montana Dental Works reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Montana Dental Works may call my home, cell or other alternative location and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out duties such as appointment reminders, insurance, and any calls pertaining to my dental care.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance to my prior consent.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information**

I authorize the release of information including the diagnosis, records, examination results,

medications, billing and claims information.

This information may be released to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identity Theft Detection and Response Policy and Procedures**

This office has adopted an Identity Theft Detection and Response Policy and Procedures Program pursuant to the Federal Trade Commission’s Red Flag Rules. The purpose of the program is to assist in detecting, preventing, and mitigating instances of possible identity theft in connection with patients in our practice. It does so by (a) requiring us to verify the identity of all new patients, (b) establishing certain “red flags” that could indicate possible identity theft and (c) requiring follow up on any incident that triggers a “red flag”. All employees of this practice including the professional, administrative, and clerical staff must observe this program

**APPOINTMENT CANCELLATION POLICY**

We strive to provide excellent dental care to our patients. This includes timely scheduling of appointments. In order to achieve this, we have an **Appointment Cancellation** **Policy**. When an appointment is scheduled, that time has been set aside for you and when it is missed it can’t always be filled with another appointment in short notice.

**Our policy is as follows:**

We require a 24-hour notice in the event that you need to

reschedule an appointment. This allows for other patients to be scheduled into

that appointment slot. If you miss an appointment without contacting our office

within the required time, this is considered a missed appointment. A fee of

$50.00 will be charged to you; this fee cannot be billed to your insurance

company and will be your direct responsibility.

If you have any questions regarding this policy, please let our staff know and we

will be glad to clarify any questions you may have.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Daniel McAllister Dr. Sarah Fontana

3 Sunset Plaza Kalispell, MT 59901

406-752-1166 Fax 406-752-1171

smile@montanadentalworks.com

DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family Members to Transfer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please forward any of the following information that you have: x-rays, probing depth chart, charting,

and photographs to Montana Dental Works.

I hereby give you permission to release any and all of my dental records to Montana Dental Works.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent if minor) Date

If records are digital, please email to: smile@montanadentalworks.com