Adult Medical/Dental History

Date:_________________________

Patient's Full Name____Nickname__________________________
Why did you come to the dentist today____
Address ____
City_____________________________ Zip_____________ Patient's Telephone _______________________________
Work Telephone # _________________ Cellular Telephone #____________________
Date of Birth____/____/___ Sex: M (__) F (__) Marital Status: Single(__) Married(__) Widowed(__) Divorced(__)
Social Security Number:_______— _______— ________ E mail Address ______________________________________
Occupation_____________________________________Employer____
Do you have any children? Yes (__) or No (__) Names and Ages of your children
1) _____________________________ 2) ________________________________ 3) ____________________________
4) ____ 5.)____
In case of an emergency, whom should be notified _________________________Tel.# __________________________
Name of Spouse (if applicable) _________________________Spouse Work Phone/Cell#_________________________
Occupation of Spouse ____Employer ______________________________
Spouse's Date of Birth _____/_____/_____ Spouse's Social Security Number ________— ______—_______________
Person responsible for account (if not yourself) ____
Whom may we thank for referring you ? (___)Sign on building (___)Yellow Pages (___)Letter/Newsletter sent to you
(___)Friend/ Family/ Employee of ours (Name: _________________________) (___)Other _______________________
Do you have dental insurance that may cover any part of our professional services? Yes(___) No(___)

Our dentist does not participate in any of the managed care dental plans (where you may only go to a dentist on a particular list). Traditional insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover at the time of service.

INSURANCE INFORMATION

Primary Insured Party's Full Name____
Social Security Number______—_____—_________
Relationship to Patient: Self(___) Spouse(__) Parent / Step Parent(__) Other (specify :__________________________)
Employer ____
Insurance Company Name____
Ins. Address ____
Ins Phone #______________________ Group or Union Name_________________Group or Local Number__________
Secondary Insurance (if applicable)
Secondary Insurance Insured's Name ____
Social Security Number ______—______—__________
Relationship to Patient: Self(___) Spouse(__) Parent/Step Parent(__) Other(specify :____________________________)
Employer ____
Insurance company Name ____
Ins. Address ____ Ins Phone # _____________________________
Special Notes ____

Physicians Name ____________________________________City ___________________________ State _________
Former Dentist's Name ______________________________________City_____________________State _________
Why are you changing dentists?

____

____
When was the last time you had a check up and professional cleaning? _________ x-rays? ____________
X-rays taken at your last visit? (___) FMX 18 x-rays (___) BWX 4 x-rays (___) Panorex 1 large x-ray(___) Don't Know
Are you having pain today? Y (__) N (__)
Please describe:____
Are you apprehensive about dental treatment Y (__) N (__) If so you are apprehensive, what of? (be very specific)

____
Have you been told to take an antibiotic before dental treatment? Y(___) N(___) Why? _________________________
Have you had (or do you have) braces? Y(___) N (___) Have you had your teeth whitened? Y(___) N(___)
Are you happy with your smile? Y(___) N(___) If not, what would you change?_______________________________
Do you smoke? Y (___) N(___), Chew tobacco/snuff? Y(___) N(___), Have you ever been told you have periodontal disease? Y(___) N(___) Do your gums bleed when you brush? Y(___) N(___) Bleed when you floss? Y(___) N(___)
Do you have pain when you open and close your mouth? Y(___) N(___), Have TMJ syndrome? Y(___) N(___)
Have you ever had any serious problems with previous dental work(___) N(___) Describe:_______________________

Have you ever had any of the following diseases or medical problems? Please Circle Y or N

Y N Heart trouble/ attack
Y N Heart murmur as a child
Y N Heart murmur currently
Y N Heart Pacemaker
Y N Mitral valve prolapse
Y N Artificial heart valve
Y N Artificial joint
Y N Hepatitis
Y N HIV + / AIDS / ARC
Y N Tuberculosis
Y N Drug/Alcohol abuse

Y N Stroke
Y N Diabetes
Y N Fainting or dizzy spells
Y N Emphysema
Y N Blood transfusions
Y N Anemia
Y N Psychiatric Treatment
Y N Ulcers
Y N Epilepsy or Seizures
Y N High Blood pressure
Y N Cortisone steroid) medicine

Y N Sinus Trouble
Y N Rheumatic Fever
Y N Jaundice
Y N Chemotherapy
Y N Radiation treatment
Y N Cancer (what kind?)________
Y N Bulimia
Y N Asthma
Y N Arthritis
Y N Fever Blisters
Y N Hemophilia

Are you allergic to any of the following?

Y N Codeine Y N Dental Anesthetics Y N Penicillin Y N Erythromycin Y N Clindamycin Y N Latex

Please list any other drugs or metals that you are allergic to:____
Please list all medications/herbs/over the counter drugs you are taking and *why* you are is taking them.

1.)____________________ for____________________
2)_____________________ for____________________
3)_____________________ for____________________

4)_____________________ for____________________
5)_____________________ for____________________
6)_____________________ for_____________________

Please list any other medical condition/congenital abnormalities that you have been treated or are being treated for:
____
Are you pregnant (___) Y (___) N (___) Possibly Are you nursing a baby? (___) Y (___) N

_______(Initial) **Broken Appointments-** I understand that appointments changed without 24 hours notice are subject to a $50.00 per hour fee.

I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

____Date________________
Signature of patient

The Montana Center for Laser Dentistry accepts several forms of payment for dental treatment provided at this office

Cash, debit card, personal check, business check (by an authorized person)
Credit Cards**;** MasterCard, Visa, American Express, Care Credit

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your benefits We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in it's covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:
1) Filing your insurance electronically (when available) within 24 hours of service and requesting payment be sent directly to us.
2) Following American Dental Association guidelines for coding procedures and filing insurance.
Our expectations of you as the owner of the policy:
1) Payment of fees not covered by your insurance plan at time of treatment.
2) Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your the insurance carrier. The insurance contract is between yourself, the carrier and possibly your employer.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment.
4) You will have to take responsibility for any fees your insurance has not covered after 60 days. The balance on your account will be charged to your credit card. If any amount is left outstanding, subsequent statements will be charged a $5.00 late fee and interest will accrue at 1.5% per month of the outstanding balance. Any expenses incurred in collecting a past due account will be added to the balance.

I hereby authorize Dr. Colonna and any Associates of The Montana Center for Laser Dentistry to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Colonna, I understand I am responsible for any unpaid balances.

I authorize Dr. Colonna to keep my signature on file AND to charge my credit card with balance of charges not paid by insurance within 61 days after treatment has been rendered not to exceed $_______________ for all visits this year.

I understand that treatment can not be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed).
I understand that if I do not have a credit card on file, it will be necessary for me to have an open Care Credit account (90 days interest free) on which The Montana Center for Laser Dentistry can charge any balances not paid with 61 days.

____Date ____________________
Responsible Party Signature

What family members are covered by this agreement?____

Credit Card on file * required*

__________—___________—___________—_   ____________________

Please circle   Exp Date