Patient Information

First name:________________________________Last name:____Middle Initial: ________

Address:____Apt. #: ________City:__________________State:_____Zip:_____________

Birth Date: ________________________ Age: _______ Social Security #: ______________________ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Primary phone: (______) _______-___________Other phone: (______) _______-___________ Text Messaging**: □ Yes □ No

Email address:____Email Messaging**: □ Yes □ No

May we leave confidential voicemail messages on any of the above phone numbers?

□ No □Yes If yes, please specify: □ Primary □ Other

How did you find our office? (Referral Source)____

Employment Status:

□ Full Time □ Part Time □ Retired □ Student If student, what school do you attend? ___________________________

Name of Employer:____________________________City, State:__________________________Work phone: (____)______-__________

Responsible Party (if someone other than patient)

First name:________________________________Last name:____Middle Initial: ________

Address:____Apt. #: ________City:__________________State:_____Zip:_____________

Birth Date: ________________________ Age: _______ Social Security #: ______________________ Sex: □ Male □ Female

Relationship to patient: ________________________________

Insurance Information (please provide insurance card)

Name of Policy Holder: _____________________________________ Policy Holder Birth Date: _____________________

Address (if different):_________________________________Apt. #: _____City:__________________State:______Zip:____________

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holder SSN – or – Subscriber ID #: _________________________

Name of Policy Holder's Employer: ____ City, State: _________________________

Name of Insurance Company: ____

Address:__________________________________Apt. #: _____City:__________________State:____Zip:____________

**We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'.

Financial Policy

Thank you for choosing Summit Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, Discover Card, or American Express
- In-house payment plans available by placing a credit card on file and filling out a credit card authorization form.
- CareCredit payment plans from CareCredit

* We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care. This discount does not apply to already reduced services or insurance co-pays.

Summit Dental requires payment at the time of service. If the there is a dental laboratory cost associated with the procedure, a payment equal to 50% of the total procedure cost must be paid prior to any lab work being completed.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, Summit Dental will only submit primary insurance claims, secondary claims are the responsibility of the patient. If we do not receive payment from your insurance carrier within 120 days, you will be financially responsible for your treatment.**

- Summit Dental charges $30 for returned checks.
- Should your account be referred to a third-party collection agency, you agree to pay all collection fees, attorney fees, and court costs.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Appointment Guidelines

Our goal is to provide quality dental care in a timely manner. Missed appointments, late cancellations, and late arrivals impede our ability to provide such care. Our office appointment guidelines are to ensure we can provide our patients with the best experience possible and enables us to better provide care to those in need.

Cancellation of an Appointment: We require a **minimum of 24hrs in advance** for all cancelled appointments. Please call, email, or respond to your text reminder that you will not be able to come to your appointment. If you cannot reach our receptionist by phone, please leave a detailed message and she will return your call to reschedule your appointment.

Missed Appointments: Failing to make a scheduled appointment without calling is considered a **"Broken Appointment" or a "No Show"** and will be recorded in your medical record as such. ***We reserve the right to dismiss you from our practice for 3 recurring "Broken Appointments."*** A cancelled appointment with 24 hrs notice does not count as a missed appointment.

Late Arrivals: In order to provide quality dental care in a timely manner, **arriving more than 15 minutes after your scheduled appointment will result in a "Broken Appointment"** and your appointment will have to be rescheduled for another date. ***We reserve the right to dismiss you from our practice for recurring "Broken Appointments."***

Account Balances: **We reserve the right to deny services for any patients with unpaid balances**. To resume appointments, a payment plan with monthly payments will need to be established with the Business Office. ****New charges will not be applied to your payment plan.***

I have read and understand the Written Financial Policy and Appointment Guidelines for Summit Dental

____ ____________________
Print Name Date

____
Signature

Please accept this document for all dependents under the age of 18.
□ Yes

Medical History

To the best of my knowledge, the questions on the medical history form I filled out have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

HIPAA Notice of Privacy Practice

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy (or can obtain a copy) of Summit Dental's HIPAA Notice of Privacy Practice.

HIPAA Release

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.

Assignment of Benefits

I acknowledge that I have received a copy of the Written Financial Policy (Assignment of Benefits) form and agree to all the terms and conditions described on the form.

General Consent for Treatment

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy (or can obtain a copy) of Summit Dental's General Consent for Treatment Form.

By signing below, I state that I have read and understand both the HIPAA Notice of Privacy Practice HIPAA Release as well as the Assignment of Benefits form. Additionally, by means of this signature, I affirm that I have filled out my Medical History as completely and accurately as possible.

____

Print Name

____________________________________ ____________________

Signature Date

Please accept this document for all dependents under the age of 18.

□ Yes

Authorization for Release of Dental Records and Patient Information

Name:____Date of Birth: ___________________________

I authorize the release of information including diagnosis, records, examinations rendered to me and claims information.

This information may be released to:

Name:_______________________________________Relationship: ____________________

Name:_______________________________________Relationship: ____________________

Summit Dental
William Samson DDS
3997 Valley Commons Dr. Ste A
Bozeman, MT 59718

**This Release of Information will remain in effect until terminated by me in writing.

Signature:____________________________________Date: ________________________

Please accept this document for all dependents under the age of 18.
□ Yes