

We would like to take this occasion to welcome and thank you for your interest in Winterholler Dentistry. We will make every effort to make your visit with us a pleasant experience. Please take a moment to review and fill out the new patient forms included in this packet prior to your appointment with us.

Educating our practice on your dental needs is an important factor for us to build our relationship with you. Please share with us your dental needs and priorities:

- _____
- _____
- _____
- _____

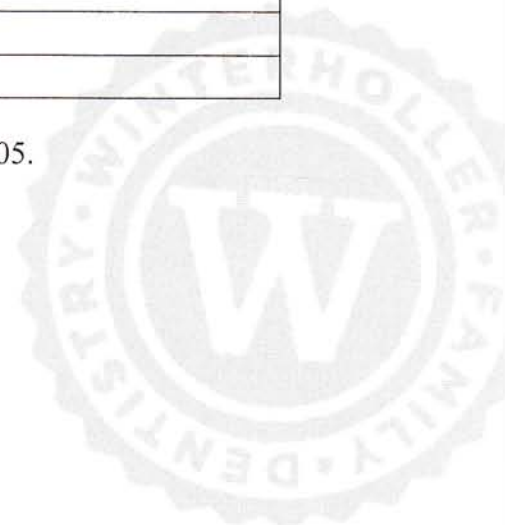
Insurance claims are filed as a courtesy to our patients. While every effort is made to assist our patients in this process, insurance information is a contract between you and your insurance company. If you would like to have insurance claims filed please provide our office with the following insurance information. Please remember to bring all completed forms with you to your appointment along with a copy of your insurance card.

Insurance Subscriber Information:

Name:	
Birthdate:	Social Security:
Employer:	
Insurance Company:	
Mailing Address:	
Phone Number:	
Group Number:	Member ID:

If you have any questions, please do not hesitate to call (406) 652-0505.

We look forward to seeing you.



PATIENT INFORMATION

Name _____ Birthdate _____ Sex: Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Number to reach you _____ SS# _____

Patient Is: Policy Holder Responsible Party Patient Is: Minor Single Married

E-Mail _____ Responsible Party (if other than patient) _____

Employment Status Full Time Part Time Retired Employer's Name _____

Employer Address _____ Employer Phone Number _____

Emergency Contact _____ Phone _____

Previous Dentist _____

Do you have, or have you had, any of the following? Please mark ONLY those that apply.

AIDS/HIV Postive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Mumor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B, or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Troubles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you allergic to any of the following:	Have you had difficulty with extractions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take any pills, drugs or herbal supplements?	<input type="checkbox"/> No
Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain _____	
Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No		
Metal <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Latex <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other _____	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you premedicate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking oral contraceptives?	
Have you been hospitalized or had a major surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain _____		

Do you prefer A.M. or P.M. appointments (please circle one)

Are you available for appointments on a short notice? Yes No (please circle one)

Financing Options

I understand that payment is due at the time of treatment. If I have dental insurance, I agree to pay my estimated co-payment at time of treatment.

All balances over 60 days are subject to a 1.5% per month billing charge.

Payment Options:

- Cash, check or credit card at time of visit
- Payment plan upon approved credit
- Automatic monthly deduction from credit or debit card until treatment is pre-paid
- Pre-treatment payment in full for diagnosed treatment – 5% discount, if paid by check or cash 24 hours in advance of appointment

I agree to be responsible for all charges which remain unpaid by my insurance after 45 days.

Please be aware that the parent bringing the child is responsible for payment.

Insurance

As a courtesy and service to our patients we will submit insurance documents on your behalf. However, we remind you that your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. Our staff will gladly submit a pre-treatment estimate to your insurance company so that you will know what your benefits will be.

The fee charged for services rendered to those who are insured are the usual and customary fees charged to all our patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Also, some companies issue payment of claims promptly while others delay payment for several months. You will be responsible for any charges which remain unpaid by insurance after 45 days.

Signature of Patient/Guardian

Date

