

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:

- _____
- _____
- _____
- _____

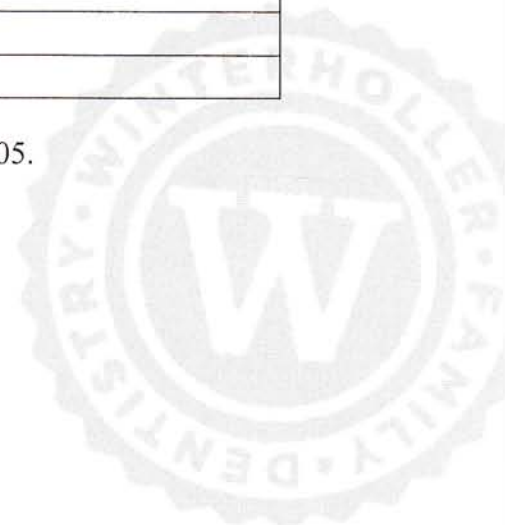
Insurance claims are filed as a courtesy to our patients. While every effort is made to assist our patients in this process, insurance information is a contract between you and your insurance company. If you would like to have insurance claims filed please provide our office with the following insurance 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)

PATIENT FINANCIAL AGREEMENT

As validated by my signature on the bottom of this form, I understand that:

- Payment is due at the time of treatment.
- A monthly statement will be sent to me for any balance due that will detail all charges, payments and credits entered on my account during the month preceding the closing date of the statement.
- No interest or finance charge will be levied against unpaid balances unless the balance is 60 days old. Interest rates will be 2% per month or 24% per annum.
- The parent bringing the child is responsible for payment.

PAYMENT OPTIONS:

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

INSURANCE:

This office will submit all insurance claims including MEDICAID. We allow thirty (30) days for insurance claims to be honored. At the end of that time, **payments must be made on all unpaid balances regardless of insurance status.** All accounts are due in full within four (4) months with payments being in four equal installments unless prior arrangements have been made. Our staff will gladly submit a pre-treatment estimate to your insurance company so that you will know what your benefits will be.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best dental care possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is “usual and customary” by a given insurance company.

Should my account become delinquent, I agree to pay reasonable collection costs, attorney fees and courts costs as permitted by law if such are incurred by this office.

Patient Account No

Patient Name

Signature of Patient/Guardian

Date

