Welcome to Montgomery Dentistry™

DR. AMY M. ANDERSON, DMD, PC + DR. JAY L. ROBERTSON, DMD, PC
DR. JOHN A. BUETTNER, DMD, PC

PATIENT INFORMATION

Patient Name: ______________________________ (______________) Date: ______________
(Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: __________ Drivers License #: ______________

Phone (Home): __________ (Work): __________ Ext: ____ Cell Phone: ______________

Address: ____
Street City State Zip Code

E-Mail Address: ____

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City State Zip Code

SPOUSE OR PARENT INFORMATION

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: __________ Drivers License#: ______________

Phone (Home): __________ (Work): __________ Ext: ____ Cell Phone: ______________

Address: ____
Street City State Zip Code

E-mail Address: ____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: ______________________ Insurance Company ______________

Insured's Birth Date: __________ ID #: ______________ Group #: ______________

Employer ______________________ Work Number: ______________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Secondary

Name of Insured: ______________________ Insurance Company ______________

Insured's Birth Date: __________ ID #: ______________ Group #: ______________

Employer ______________________ Work Number: ______________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

EMERGENCY CONTACT

Name ______________________ Phone number ______________
Nearest relative not living with you

REFERRAL

How did you hear about Montgomery Dentistry? (Circle any that apply) Google™, Yahoo™, Bing™, HIBU/Yellowbook™, Yellow Pages™, Insurance Company, Personal Referral (please provide name): ______________

Other (please describe): ______________________

FINANCIAL RESPONSIBILITY AND CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Due to changes and the standardization of The Health Insurance Portability and Accountability Act (HIPAA) you will see a more precise listing of procedures and fees. I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Montgomery Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. Any appointment needing to be rescheduled that does not receive 48 hours notice may be subject to a $50.00 charge. This charge is above and beyond any estimate for treatment. I authorize the release of past medical/dental payment history and/or a credit report. If the amount owed is more than what is estimated per the Payment Plan Authorization Form, the Patient (Parent or Guardian if minor) agrees to the continuation of payments as agreed by said form until the balance is paid in full. **In the event that payments are not received by the agreed upon dates, I understand that a finance charge of 1.5% each month there is a balance may be added to my account. Statements are sent once a month and payable within 10 days of receipt of statement.** I authorize the merchant to convert my check to Electronic Funds Transfer (EFT) or paper draft, and to debit my account for the amount of the transaction. In the event that my draft or EFT is returned unpaid, I agree that a fee as allowable by law may be charged to my account via draft or EFT. **AGREEMENT TO PAY**: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State**. EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:** You agree, in order for us to service your account or to collect monies you may owe, Montgomery Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Montgomery Dentistry, its employees and/or agents may contact me/us as described above. I have read the above conditions of treatment and payment and agree to their content.

____ Date: ______________
Signature of Responsible Person (Parent or Guardian if Minor)

Entered in Dentrix by: __________

PATIENT INFORMATION

DENTAL HISTORY

Do you have a specific dental problem? Describe____YES NO

When was your last Dental visit? ___________________ Name of previous Dentist _______________________________

Do you think you have active decay or gum disease? ____YES NO

Do your gums bleed? Discuss ____YES NO

Do you feel nervous about having dental treatment? ____YES NO

Have you ever had a bad experience in a dental office? Describe _______________________________________YES NO

Do you like your smile? Why? ____YES NO

Do you ever grind or brux your teeth? Discuss ____YES NO

Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss ___________________YES NO

MEDICAL HISTORY

Medical Doctor's Name ____________________ Address _________________________ Phone ____________________

Are you under a doctor's care now? Why? ____ YES NO

Are you allergic to any medications or substance? What? _______________________________________ YES NO

Have you ever been told that you need to Pre-Medicate prior to dental treatment?____________________YES NO

Do you take any kind of blood thinner? ____ YES NO

Do you smoke or use tobacco products? ____ YES NO

Women Only: Are you pregnant? YES, month? _____________ NO. Nursing? YES NO Taking birth control pills? YES NO

Have you ever had any of the following? Please circle those that apply:

AIDS/HIV Pos.	Allergies	Anemia	Artificial Joints	Asthma	Blood Disease
Cancer	Cold Sores	Cosmetic Surgery	Diabetes	Dizziness	Epilepsy
Excessive Bleeding	Fainting	Glaucoma	Growths	Hay Fever	Head Injuries
Heart Disease	Heart Murmur	Hepatitis _____	High Blood Pressure	Jaundice	Kidney Disease
Liver Disease	Mitral Valve Prolapsed		Nervous Disorder	Pacemaker	Ulcers
Psychiatric Care	Radiation Treatment		Respiratory Problems	Rheumatic Fever	
Rheumatism	Sinus Problems		Special Needs Pt.	Stomach Problems	
Stroke	Tuberculosis	Tumors	Venereal Disease	Walker/cane	Wheelchair

Have you had any recent surgery?____

Have you had any serious illness not marked above? ____

FINANCIAL RESPONSIBILITY AND CONSENT FOR SERVICES

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Due to changes and the standardization of The Health Insurance Portability and Accountability Act (HIPAA) you will see a more precise listing of procedures and fees. I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Montgomery Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. Any appointment needing to be rescheduled that does not receive 48 hours notice may be subject to a $50.00 charge. This charge is above and beyond any estimate for treatment. I authorize the release of past medical/dental payment history and/or a credit report. If the amount owed is more than what is estimated per the Payment Plan Authorization Form, the Patient (Parent or Guardian if minor) agrees to the continuation of payments as agreed by said form until the balance is paid in full. **In the event that payments are not received by the agreed upon dates, I understand that a finance charge of 1.5% each month there is a balance may be added to my account. Statements are sent once a month and payable within 10 days of receipt of statement.** I authorize the merchant to convert my check to Electronic Funds Transfer (EFT) or paper draft, and to debit my account for the amount of the transaction. In the event that my draft or EFT is returned unpaid, I agree that a fee as allowable by law may be charged to my account via draft or EFT. **AGREEMENT TO PAY**: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State**. EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:** You agree, in order for us to service your account or to collect monies you may owe, Montgomery Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Montgomery Dentistry, its employees and/or agents may contact me/us as described above. I have read the above conditions of treatment and payment and agree to their content.

____ Date:____________________

Signature of Responsible Person (Parent or Guardian if Minor)

Doctor Signature: ____

FOR OFFICE USE ONLY:

B/P __________, Pulse _______ TAKEN BY _________, DATE _____________

B/P __________, Pulse _______ TAKEN BY _________, DATE _____________