Montana Center for Laser Dentistry, PLLC
6516 US Hwy 93 S, Whitefish, MT 59937 Office: (406) 862-1010 Fax: (406) 863-9090
1874 Highway 93 N Kalispell, MT 59901 Office: (406) 730-1010 Fax: (406) 393-2460

Personal Information

Patient's Name: ______________________________ Nickname: __________
Last First MI Mr. Ms. Mrs. Dr.

Date of Birth: ____/____/______ SSN: _____-_____-_____ ☐Single ☐Married ☐Child ☐Other

Mailing Address ______________________________
Street City State Zip

Home Ph: (____) __________ Cell Ph: (____) __________ Work Ph: (____) __________ Preferred #: ☐H ☐C ☐W

E-mail: ______________________ Referred By: ______________

Employer/School: ______________ Occupation: ______________ How long there? ______

Who may we thank for referring you? ______________________________

Spouse's or Parent's Information

Name: ______________________ Relation: __________ Ph: (____) ______

Employer: ______________________ Title: __________ How long there? ______

Name: ______________________ Relation: __________ Ph: (____) ______

Employer: ______________________ Title: __________ How long there? ______

Emergency Contact

Name: ______________________ Relation: __________ Ph: (____) ______

Person financially responsible for account if other than yourself

Name: ______________________ Relation: __________ Ph: (____) ______

Address: ______________________________
Street City State Zip

Dental History

Most recent cleaning? __________ Most recent visit? __________ What was done? __________

Previous Dentist: ______________ City, State: ______________ Ph: (____) ______

How often do you brush? ______ Floss? ______ Any additional hygiene aids? __________

Have you ever had any of the following conditions? Please circle "yes" or "no" for ALL

Y N Bleeding Gums	Y N Tired Jaws	Y N Periodontal (Gum) Treatment
Y N Tender/Swollen Gums	Y N Clenching Teeth	Y N Endodontic (Root Canal) Treatment
Y N Loose Teeth	Y N Burning Tongue	Y N Complicated Extraction
Y N Sensitive Teeth	Y N Sinus Conditions	Y N Crown (Cap) or Bridge
Y N Mouth Sores	Y N Fear of Dentistry	Y N Removable Dentures
Y N Pain in Mouth	Y N Sedation for Dental Work	Y N Dental Implants
Y N Ear Ache	Y N Orthodontic (Braces) Treatment	Y N Oral Habits __________

Please describe any unusual dental experience: ______________________________

Please list any medication you need to take prior to dental work: ______________________________

Medical History

Last Visit to Physician: ____________Reason: ____________

Physician's Name: ________________________City, State: ______________________ Ph: ( ) ____________

What drugs or medications are you taking now and why? ____________

Have you ever had any of the following conditions?

Y N Rheumatic Fever
Y N Heart Murmur/Condition
Y N Pacemaker/Other Device
Y N Prolonged Bleeding
Y N Herpes I or II
Y N AIDS/HIV
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Cancer/Malignancy/Tumor
Y N Artificial Joint/Rod
Y N Stroke? Heart attack

Y N Deaf/Hard of Hearing
Y N Diabetes
Y N Epilepsy/Seizures
Y N Tuberculosis
Y N Hepatitis
☐ A ☐ B ☐ C ☐ D
Y N Radiation/Chemotherapy
Y N Mentally Challenged/Autistic/CP
Y N Nervous Problems/Psychiatric Care
Y N Major Surgery ______________
YN Bisphosphonates

Y N Arthritis
Y N Asthma
Y N Sleep Apnea

Allergic to:

Y N Aspirin-Ibuprofen-Tylenol
Y N Penicillin
Y N Codeine
Y N Dental Anesthetics
Y N Latex
Y N Other ______________________

Women: Are you pregnant or could you be pregnant?_____________

If you marked YES to any of the answers above, please explain: ____________

How much/often do you smoke, including e-cigarettes?_________Drug or alcohol use?____________________________

What hospitalizations have you had in the past 5 years? ____________

Any other medical information the doctor should be aware of? ____________

Dental Insurance

Will you be using dental insurance?____

Name of Dental Insurance Company____

Patient Consent

I hereby consent to the treatment requested by me, including but not limited to the taking of photographs and dental radiographs for diagnostic, promotional and educational purposes, and the use of local anesthetics, relaxant medicines, laughing gas or a combination as required for completing treatment rendered. I understand that perfect results cannot be guaranteed. I certify that all the above information is true and correct to the best of my information, knowledge and belief.

Patient's Signature (Parent/Guardian) ____________ Date ____________

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Communication Authorization

Patient's Name: ____ Date of Birth: / /
Last First MI

____
Patient mailing address City State Zip

I, ___________________________________, (☐ Patient ☐ Parent/Guardian) give permission to

The Montana Center for Laser Dentsitry, PLLC. to discuss the

☐ following: Diagnosis, prognosis and/or treatment

☐ information Scheduling information

☐ Billing information

☐ Other (please specify):

with the following people:

______________________________ Relation:________________ Ph:______________________________

______________________________ Relation:________________ Ph:______________________________

______________________________ Relation:________________ Ph:____________________________

☐ Leave messages on my cell voicemail

☐ Leave messages on my home answering machine

☐ Leave messages on my work answering machine/voicemail

☐ Send e-mails and/or text messages (may opt-out at any time after receiving initial e-mail or text)

☐ Leave messages with members of my household

Consent for Use and Disclosure of Health Information – HIPAA

Effective October 9,2017

Purpose of Consent: By signing this form, you consent to our using and disclosing your protected health information in order to treat you, to collect payment, and to care for your health.

Notice of Privacy Practices: A copy of our Notice of Privacy Practices can be found in our waiting room and on our website, www.mtlaserdentistry.com. It provides a detailed description of how we may use your protected health information. Before signing this consent, we encourage you to carefully read our Notice of Privacy Practices.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, and you will be asked to sign this consent again.

Changing Your Permissions: If your household situation changes, it is your responsibility to file a new Communication Authorization with us. If you fail to notify us, we are not responsible for unwanted communications. The permissions you give on this form will be considered current until you file a newer form with us.

Right to Revoke: You have the right to revoke this consent at any time. To do so, give written notice of your revocation to Kaytlyn Tinnel at the address above. Revocation of this consent will not apply retroactively. Revoking this consent may mean that we may decline to treat you, or to continue treating you.

____
Patient/Parent/Guardian's Signature Date