Ambulatory Dental Anesthesia OF MONTANA

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Patient Registration Form

Date: ____/____/____ DOB: ____/____/____ Age: ____ SSN: _____ ☐ Male ☐ Female

Patient name: _____
Last First MI

Permanent Mailing Address: _____ _____
Street City State Zip email address

Home phone (_____)_____ Cell phone (_____)_____ Work phone (_____)_____

Employer: _____ **Is the patient a child or dependent adult? ☐ Yes ☐ No**

Address: _____
Street

_____ Occupation: _____
City State Zip

Email address: _____

Guardian/Spouse name: _____ Occupation: _____

Employer: _____ Work phone: (_____)_____

Address: _____ Cell phone: (_____)_____
Street

_____ Email address: _____
City State Zip

Emergency Contact Information

Name: _____ Relationship: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

In the event of an emergency, I authorize Dr. Klise and/or one of his delegates to contact this individual and discuss my medical condition.

Signature: _____ Name printed: _____
Patient or guardian

Responsible Party Information

Is the patient the responsible party? ☐ Yes ☐ No

If no, name of individual insured: _____

Primary Insured: _____	Secondary Insured: _____
Primary Insurance: _____	Secondary Insurance: _____
Insurance Address: _____ Street _____ City State Zip	Insurance Address: _____ Street _____ City State Zip
Group no.: _____ Policy no.: _____	Group no.: _____ Policy no.: _____
Montana Medicaid Information: Number: _____	Montana CHIP information: Number: _____

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Financial Agreement

Payment arrangements for anesthesia services with Ambulatory Dental Anesthesia of Montana, P.C. are required prior to the anesthesia appointment. Anesthesia services are billed separately from dental fees submitted by the treating dentist. Ambulatory Dental Anesthesia of Montana, P.C. accepts assignment of benefits as full payment from Montana Medicaid/ Healthy Montana Kids Plus and CHIP/Healthy Montana Kids. We also accept the following forms of payment for self-pay patients: Cash®, Visa®, MasterCard® and Discover®, money order and check. A usual and customary fee will be assigned for all checks returned due to insufficient funds. Payment in full is required at the time of the procedure for all 3rd party insurance or self-pay.

Insurance Coverage: Ambulatory Dental Anesthesia of Montana, P.C. will file claims with Medicaid and CHIP with no payment due at the time of service, pending verification of eligibility with the appropriate agency.

3rd Party/Self-pay: All 3rd party insurance or self-pay patients will be expected to pay in full at the time of service. A detailed invoice will be provided for you to submit to your insurance for reimbursement of services. We will not bill any 3rd party insurance companies. It is the responsibility of the patient or guardian to verify that insurance coverage for dental anesthesia is covered by their insurance company. Any funds paid to Ambulatory Dental Anesthesia of Montana, P.C. by 3rd party insurance that has been previously paid by the patient will be reimbursed to the patient. If you are unable to pay in full at the time of service, arrangements must be made in advance or we reserve the right to cancel the procedure.

Collections: Failure to uphold payment agreements arranged between Ambulatory Dental Anesthesia of Montana, P.C. will result in assignment to a local collection company. Should the balance be turned to collections, you will be responsible for all third party collection fees including, but not limited to, interest on the unpaid balance up to the maximum allowed by law, collection agency fees and court costs and fees.

By signing below I certify that I am the patient or the legal guardian of the patient. I have read and understand the financial agreement of Ambulatory Dental Anesthesia of Montana, P.C. and accept full responsibility for all fees incurred for treatment by Dr. Klise.

I confirm to the best of my knowledge that all information provided to Ambulatory Dental Anesthesia of Montana, P.C. on this **Patient Registration Form** is accurate. Additionally, I have read , understand, and agree to the terms of payment to Ambulatory Dental Anesthesia of Montana, P.C. established under the **Financial Agreement** section.

Signed: _____ Date: ____/____/____

Patient or legal guardian

Name printed: _____