Dr. Heather Moore D.D.S.

www.yourgreatfallsdentist.com

homegrowndentalmt@gmail.com

2507 6th Ave South

Great Falls, MT 59405

Phone: (406) 459-3301

**NEW PATIENT INFORMATION**

**Patient Details**

Patient Name: DOB:

Address:

City: State: Zip:

Gender: M F Age:

Marital Status: Single Married Domestic Partner Divorced Widowed

Social Security Number:

**Contact Information**

Home Phone Number: Cell Phone Number:

Work Phone Number: Work Extension Number:

How do you prefer to be contacted? Phone Text Email

How did you hear about us?

**Emergency Contact Information**

Notify in case of Emergency:

**Primary Dental Insurance**

Do you carry dental insurance? Yes No

IF YES; PLEASE FILL OUT BELOW

Primary Insurance: Group#:

Employer: Insured Name:

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**Secondary Dental Insurance**

Do you carry a secondary dental insurance? Yes No

IF YES; PLEASE FILL OUT BELOW

Secondary Insurance: Group#:

Employer: Insured Name:

**Financial Policy**

We are proud that our fees reflect the excellent service and care we provide. Dental treatment is an excellent investment in an individual's medical & psychological well-being. The following is a statement of our financial policy. Financial considerations should not be an obstacle to obtaining this important health service. Therefore, we provide the following payment II options:

* **In-Office Payment** Patient portion of treatment (after the estimated insurance benefit) is due when treatment begins. If an individual in unable to pay their portion in its entirety, we accept half down with the remaining portion spread evenly over 90 days with no finance charge. \*We accept cash and checks, as well as Visa, MasterCard, American Express, and Discover\*
* **Care Credit Payment** plans ranging from 3 to 60 months. An 18% per year (1.5% per month) finance charge is applied to all balances unpaid after 90 days. Alt returned checks are subject to an additional collection fee.

**Appointment Cancellation**

* We realize that emergencies come up, however, if you need to cancel for any reason, we request that every attempt is made to give us 48 hours’ notice. If you do not contact our office 24 hours prior to your appointment time, then we reserve the right to charge a fee. Thank you in advance for your consideration regulating this matter

**Insurance**

We are happy to process most insurance claims as a service to you at no charge. Through insurance verification, we can obtain a breakdown of your plan benefits and determine an estimated percentage of the total fee to be paid at your first visit. (This is your estimated copayment.) Our fees are not related to your coverage. You and your employer purchase

your coverage. Please realize that professional health care is rendered to you, the patient, not an insurance company. Even though we accept the assignment of benefits that allows your

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insurance company to pay us directly, you are responsible for any amount not paid by your plan. Thank you for reviewing and understanding our policies. Please let us know if you have any questions.

I have read, understand, and agree to the above financial policy and appointment cancellation policy I authorize my insurance company to pay my dental benefits directly to **Homegrown Dental LLC**. The undersigned acknowledges that our Notice of Privacy Practices has been made available.

Signature: Date: