PATIENT INFORMATION FORM

Buffington DENTAL

Patient (Legal) Name:_____ Preferred Name:_____
Birth Date:_____ Male:☐ Female: ☐
Married: ☐ Single: ☐ Divorced: ☐ Minor: ☐ Other: ☐ _____
Mailing Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____ E-mail:_____
Patients Employer:_____ Work Phone #:_____
Name of Person Responsible for Account:_____
Spouse Name:_____ Spouse Birthdate:_____
Spouse Employer:_____ Spouse Work Phone:_____
Whom may we thank for referring?_____

Nearest Relative/Friend Not Living With Patient

Name:_____ Relationship:_____
Address:_____ Phone:_____

About Your Dental Insurance – We will need a copy of all insurance cards

Primary	**Secondary**
Employee Name:_____	Employee Name:_____
D.O.B:_____	D.O.B.:_____
SS#:_____	SS#:_____
Employer:_____	Employer:_____
Insurance Co:_____	Insurance Co:_____
Policy #:_____	Policy #:_____
Phone #:_____	Phone #:_____

Complete this Section If Patient is Under The Age of 18 or a Student

Mother's Name:_____	Father's Name:_____
Address:_____	Address:_____
_____	/
Employer:_____	Employer:_____
Work #:_____	Work #:_____

0I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.

0I understand that I am financially responsible for all charges whether or not paid by my insurance.

0I understand that should I default on my payment of my account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of my account.

0I certify that I have read & understand the above information to the best of my knowledge. The above questions have been accurately answered.

Patient or Guardian Signature:_____ Date:_____

Neal J. Buffington DDS
604 1st Avenue West | P.O. Box 1120
Columbia Falls, MT 59912
t. (406) 892 4296
f. (406) 892 5431
www.columbiafallsdental.com
info@columbiafallsdental.com

Appointment Cancellation Policy

We make every effort to schedule your appointment at the most convenient time. It is very important that you keep your appointments as scheduled. Please call our office at least 24 hours in advance if you cannot make your appointment, so that we may give the time to another patient in need of care. A fee may be charged for appointments cancelled without 24 hours notice.
Initial_____

Consent for use & disclosure of health information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I understand that providing incorrect information can be dangerous to my health.
Initial_____

Acknowledgement of receipt of notice of privacy practices

I agree to this office's Notice of HIPPA Privacy Practices. A copy is available to me at my request.
Initial_____

Financial

To reduce our administrative cost and keep our fees to you as low as possible, we ask that you pay at the time of service. Please indicate below the method of payment you intend to use to pay for your dental treatment, including your co-payment.

- ☐ Cash/Check
- ☐ Visa/MC/Amex/Discover
- ☐ Care Credit (payment option – needs to be approved thru GE Fin.)

I consent to examination, treatment and procedures (including being current with radiographs) which may be performed during office visits, including emergency treatment considered necessary by the Dentist.

Patient or Guardian Signature:_____Date:_____

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