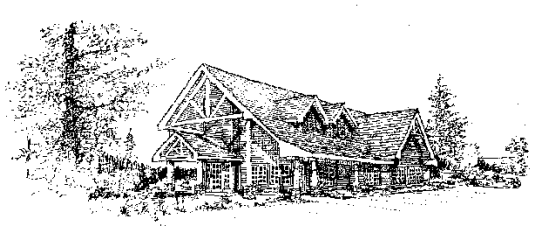


DALEN DENTAL CLINIC
Jeffrey A. Dalen, D.D.S.
P: 406-862-4301 Fax:406-862-9347

Welcome to our office. We appreciate the confidence you place with us to provide dental services.

Personal Information

Name: _____

SS#: _____ Or DL#: _____

Address: _____ City: _____ State/ZIP: _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

Birth date: _____ Gender: _____ Marital Status:_____ Spouse Name: _____

Occupation: _____ Referred by: _____

Person Responsible for Account

Name: _____ Relationship _____ SS#: _____

Address: _____ City: _____ State/ZIP: _____

Telephone: Home: _____ Work: _____

Dental Insurance Information

Primary Insurance Co: _____

Employee: _____ Relationship: _____

SS#: _____ Birth Date: _____

Employer: _____ Policy #: _____

Secondary Insurance Co.: _____

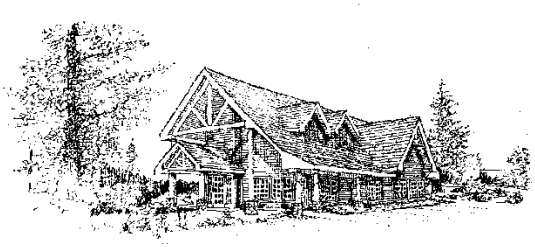
Employer: _____ Policy #: _____

A service charge of 1.25% per month (15% annual rate) will be applied to balances over 90 days, $0.50 minimum charge. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting the permission.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Jeff Dalen.

Signature required _____ **Date** _____

Your answers are for our records only and will be kept confidential in accordance with applicable laws.



DALEN DENTAL CLINIC
Jeffrey A. Dalen, D.D.S.
P: 406-862-4301 Fax: 406-862-9347

Patient Name: _____ Date: _____

Health Information

Personal Physician Name: _____

Personal Physician Address: _____

Yes	No	
◯	◯	1. Have you been hospitalized within the past 2 years? For what? _____
◯	◯	2. Are you currently being treated by a physician? For what? _____
◯	◯	3. Are you currently taking any medications or drugs? What? _____
		_____
◯	◯	4. Do you have any history of alcohol or drug abuse? _____
◯	◯	5. Are you allergic to any medications? What? _____
◯	◯	6. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____
◯	◯	7. Are you allergic to any metals? What? _____
◯	◯	8. Do you bleed excessively upon injury? _____
◯	◯	9. Are you pregnant? _____
◯	◯	10. Are you taking bisphosphonates? _____ (used for osteoporosis or chemotherapy)

Circle any of the following conditions that you have had or now have:

☐ **AIDS**	☐ **Glaucoma**	☐ **Kidney Problems**	☐ **Sexually Transmitted Diseases**
☐ **Arthritis**	☐ **Heart Murmur**	☐ **Low Blood Pressure**	☐ **Stroke**
☐ **Asthma**	☐ **Heart Problem***	☐ **Nervous Breakdown**	☐ **Tuberculosis**
☐ **Cancer**	☐ **Hepatitis A,B,C**	**or Psychiatric Therapy**	☐ **Other Diseases***
☐ **Diabetes**	☐ **High Blood Pressure**	☐ **Osteoporosis**	☐ **Joint Replacements**
☐ **Epilepsy**	☐ **Jaundice**	☐ **Rheumatic Fever**	**What _____ When _____**

***Please give further explanation:** _____

Person to be contacted in case of emergency:

Name: _____

Address: _____

Telephone: (Home) _____ **(Work)** _____

Dr initial:_____