

**Jesse McClung DDS
CENTER
108 N. 11th Ave. Suite #2
Bozeman, MT 59715
Phone #: 406-586-5949
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BIG SKY DENTAL

Patient Information

Patient Name: _____ M - F
Address: _____
Birthdate: _____ Social Security #: _____
Driver Lis.#: _____ Home phone #: _____
Cell Phone#: _____ Work Phone#: _____
EMAIL ADDRESS: _____
Employer: _____
Spouse Name: _____
Spouse Employment _____
Spouse Work phone #: _____ Cell phone #: _____
In case of an Emergency:
Physician: _____ Phone#: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER 18 OR A STUDENT

Parent's Name: _____
Mother's Social Security #: _____ Mother's DOB _____
Mother's Employer _____ Wk phone#: _____
Father's Social Security #: _____ Father's DOB _____
Father's Employer _____ Wk phone#: _____

Nearest Relative /Friend not living with Patient

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

About your Insurance-Please provide copy of your current Insurance card

Primary Insurance: _____
Who is the Primary Insured: _____
DOB: _____ ID# _____ Group# _____

Whom may we thank for referring you to our office? _____

IMPORTANT INFORMATION-PLEASE READ

- I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by Dr. McClung and /or his designated providers. _____
- I authorize the release of any medical information necessary for treatment and to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable. _____
- I understand that I am financially responsible for all charges whether or not paid by my insurance. _____
- I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account. _____

Patient or Guardian Signature: _____ Date: _____

Printed Name: _____