MONTANA
CENTER FOR
IMPLANTS & DENTURES

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Patient Name: _____

DOB: _____ Today's Date: _____

Patient's Phone #: ( )

Referrer: Dr. _____

APPOINTMENT

Date: Time:

☐ Please call patient to set up appointment ☐ Patient will call to set up appointment

PATIENT INSTRUCTIONS

Please bring the following to your first appointment:

(1) New patient forms (they will be emailed or texted to you a few days before your initial visit)

(2) List of any medications you are currently taking

(3) Insurance card (if applicable)

You may receive a phone call from our office if we require any additional information prior to your appointment.

Additional information is available at montanaimplants.com

REFERRING OFFICE

Please email us relevant radiographs, insurance information, etc. that will help your patient receive quality and timely care.

Comments? Concerns? Please do not hesitate to contact us at (406) 259-7115 or at info@montanaimplants.com
More info at montanaimplants.com

PLEASE CIRCLE TEETH TO BE TREATED

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Right *Left*

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

CHECK ALL THAT APPLY

IMPLANTS

☐ ALL ON X ☐ IMPLANT OVERDENTURE

☐ SINGLE UNIT IMPLANT(S) ☐ IMPLANT REPAIR

FINAL RESTORATION

☐ PLEASE RESTORE ☐ RETURN PATIENT FOR RESTORATION

DENTURES

☐ DENTURE ☐ PARTIAL

OTHER

☐ EXTRACTIONS ☐ BONE GRAFTING/SINUS LIFT

☐ CBCT/3D IMAGING ☐ SOFT TISSUE GRAFTING

REMARKS (Relevant med Hx, concerns, periodontal status, etc.):