



Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception; dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

Sincerely,

Purpleplum Dentistry

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Signature

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Date



Dear Patient, I would like to thank you and welcome you to our office.  
I'll start by sharing with you what our guiding beliefs are for our patients.

Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires.

With that in mind we would ask you to identify how you would like to be seen in our office by checking which of the 3 levels seem appropriate for you at this time. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this helps as a starting point.

- Level 1: Reactive care, patients at this level are generally only interested in solving more urgent problems and not in a comprehensive exam or long term planning. In addition they typically want the treatment performed to be as inexpensive and efficiently as possible.
- Level 2: Proactive care, patients who choose this level of care generally want a thorough examination and want to be involved in the prevention of present and future dental problems.
- Typically however they choose repair solutions that are not long term in nature.
- Level 3: Regenerative care, patients at this level have a high value for their dental health and appearance. They desire a complete dental examination and have a desire to be informed of all findings and the potential consequences of each problem. Ultimately they want to be involved in creating a long term master plan for their dental health which includes choosing the longest lasting solutions to their problems.
- We hope these different levels make sense to you, and as we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

## PATIENT REGISTRATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

**Responsible Party** (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism Scarlet <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Fever Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No | \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Dental Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

What are your goals in coming to our practice today? \_\_\_\_\_

What is important to you in a dentist or dental practice? \_\_\_\_\_

What has been your experience with the dentist in the past? \_\_\_\_\_

Date of last radiographs (x-rays) and exam \_\_\_\_\_

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you left your previous dentist, what are the reasons? \_\_\_\_\_

Have you had problems with prior dental treatment? \_\_\_\_\_

Are you experiencing any pain now?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been pre-medicated for dental treatment?  Yes  No

If yes, why? \_\_\_\_\_

Have you been anxious about having dental treatment?  Yes  No

If yes, would you be comfortable sharing why? \_\_\_\_\_

Would you like to discuss this concern with the doctor to learn about your relaxation options? \_\_\_\_\_

What concerns do you currently have with your oral health or smile? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain                 | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite                         | <input type="checkbox"/> Food gets caught in between teeth              |
| <input type="checkbox"/> Discolored teeth               | <input type="checkbox"/> Underbite                        | If yes, where? _____  |
| <input type="checkbox"/> Crowding/Crooked teeth         | <input type="checkbox"/> Uncomfortable bite               | <input type="checkbox"/> Difficulty chewing                             |
| <input type="checkbox"/> Missing teeth                  | <input type="checkbox"/> Old fillings (gold or silver)    | If yes, where? _____  |
| <input type="checkbox"/> Spaces in between teeth        | <input type="checkbox"/> Old crowns                       | <input type="checkbox"/> Bad breath                                     |
| <input type="checkbox"/> Loose tooth/teeth              | <input type="checkbox"/> Speech problems                  | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Tooth shape or size            | <input type="checkbox"/> Too much gum tissue when I smile |   |

Have you ever had orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?  Yes  No

If yes, when? \_\_\_\_\_

Have you whitened your teeth in the past?  Yes  No

If yes, what method? \_\_\_\_\_

Are you interested in learning more about the following? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening       | <input type="checkbox"/> Tooth-colored fillings             | <input type="checkbox"/> At-home oral hygiene care                  |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants                    | <input type="checkbox"/> Periodontal treatment during pregnancy     |
| <input type="checkbox"/> Veneers               | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |



## Financial Policy

Thank you for allowing purple plum dentistry to provide you with the best care for your dental needs. We ask you for your understanding and appreciate your cooperation with our financial policy.

**Payment options:** Payment is due at the time of service unless alternative agreements have been made in advance.

- Open an account with care credit card and received interest-free options
- Pay by cash check or credit card

**Regarding insurance:** If you have insurance, and wish us to wait for payment, we will submit claims to your insurance carrier. Co-pays are due at the time of service. If your insurance carrier does not compensate the office for services rendered within 45 days the balance will then revert to the responsible party. The balance due (Unless prior arrangements have been made) must be paid in full within 30 days

**Note:** Please remember that the insurance quotes are only estimates. Your dental insurance is based upon contract between the subscriber's employer and insurance carrier. The benefits that are discussed with you at the time of your appointment are not guaranteed payments from the insurance carrier. You may be billed after the insurance payment is received for an additional payment.

**Return checks:** Personal checks that are returned due to "Insufficient funds" Are subject to a \$50 service fee

**Missed appointments:** Please carefully schedule your appointments and help us treat our patients by keeping your scheduled appointment. A fee of \$60 is charged for every 30 minutes of a recall appointment that is missed without a 48-hour notice.

**X-ray release:** There's a fee of \$30 for a release of x-rays and or records.  
I have read and understand the financial policy of purple plum dentistry. I agreed to be responsible for payment in terms of all services rendered on my behalf of my dependents.

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Patient Signature

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Date



**Acknowledgement of Receipt of Notice  
Of Privacy Practices**

**\*\*\*You May Refuse to Sign This Acknowledgement\*\*\***

I, \_\_\_\_\_, have received/read a copy of this office's  
Notice of Privacy Practices

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

WE VALIDATE PARKING TICKETS FOR THE VISITOR PARKING BEHIND THE BUILDING BRING YOUR TICKET UP WITH YOU OR/

PLEASE PARK IN OUR DESIGNATED PARKING SPOTS



- Coming from **Leesburg Pike/Route 7** turn onto **S Jefferson St.** (across from Bailey's Cross Rd shopping center)
- Stay on your Right side
- Proceed down parking ramp located all the way to your right with the sign **G2 level, skyline 1,2,3 Permit Parking& Target Deliveries/reserved**
- Once down the ramp, Make a **Left** at the first **Stop Sign** (Do not enter any of the gated parking on the right).
- Reach the next **Stop sign**, slightly passed the stop sign, our reserved parking spots are at the left in the middle row designated with purple signs.
- The walls have a green band indicating **Sky 1 G2 level**.
- Please walk back in the direction you drove, to sky1 where you see a sign says **Mailroom/lobby**.
- When you pass the mailroom, you will see the 6 elevators.
- We are on 14<sup>th</sup> floor. **Suite# 1406**.