



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,

Alpine Dental

Signature

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.



Cancellation Policy for Dental Appointments

We understand that cancellations are sometimes unavoidable, but the scheduling time lost is extremely costly to our practice. **Due to the high costs involved in having the appointment time available for you, effective January 1st, 2022 there is a missed appointment charge of \$100 per Hygiene scheduled and \$100 per ½ hour scheduled for other procedures.** These fees are not covered by insurance, it is the sole responsibility of the patient, and it must be paid in full prior to the patient's next appointment. **Initial**

We utilize emails and text messaging to remind you of upcoming appointments. A reminder is sent two weeks prior to your appointment so that you may choose to reschedule if needed. An additional email and/or text message is sent 48 hours prior, allowing you to confirm the appointment by email or a return text message response. It is your responsibility to confirm the appointment as most hygiene appointments are made 6 months in advance. If you chose to opt-out of this communication, we are not responsible to remind you by phone. If your schedule is constantly changing and does not permit advance scheduling, you can request to be added to our quick fill list for same day/last minute openings.

- **Cancellation or rescheduling of an appointment with more than 48 hour notice will result in no charge. You can cancel by calling 703-998-4244 or respond to text. **Initial****
- **A failed appointment is considered one that is cancelled/rescheduled less than 48 hour notice, or one where patient does not show up to a confirmed appointment. **Initial****
- **If you are more than 15 minutes late to your appointment without providing an advance notice it is considered a missed appointment, and may result in a cancellation fee – in the event we have same day reschedule, your fee may be waived. **Initial****
- **We allow one broken appointment at no charge per calendar year as a courtesy. **Initial****
- **After two failed appointments, we will require a deposit up to a 100% that will be applied to your appointment, to reserve any further appointments. **Initial****
- **After 3 failed appointments you risk being dismissed from our practice for lack of respect for our time. **Initial****
- **An unconfirmed Hygiene appointment within 1 week is considered a non appointment and it will be canceled. **Initial****
- **For specialty services provided at our office by a visiting dentist or larger restorative/cosmetic appointments we will require a deposit to reserve the appointment spot. **Initial****

Patient Signature _____

Date _____



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 Other
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

Section 3

Employment Status: Full Time Part Time Retired

Additional Comments:

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

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 Alpine Dental 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 \$100 is charged for every 30 minutes of an 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.

Patient Signature

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)

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)