Alpine Family Dental

101 Westview Park Place
Kalispell, MT 59901
406-752-1107

Patient Information

Last Name:________________________________ **First Name:** _______________________________ **Middle Initial:**_____ **Date of Birth:**____________

Preferred to be called: _______________________________

Mailing Address: ____ **City, State, Zip:** ____

Cell Phone:________________________________**Work Phone:**_______________________________**Home Phone:**______________________________

Email:____ **SS#:**_____________________________________

Pharmacy:____ **Primary Physician :**____________________________________

How would you prefer to be contacted for appointment reminders? Text Email Phone (circle all that apply)

Patient Is:

[ ] Policy Holder for Insurance
[ ] Responsible Party

Emergency Contact Name:____ **Phone #:**____

How did you hear about our office: [ ] Internet Search [ ] Patient Referral [ ] Website [ ] Other:_____________________

If you were referred by another guest, who may we thank?____

Responsible Party Information

(Please fill out if different from patient, responsible party must be present to sign financial agreement)

[ ] Same As Above

Last Name:________________________________ **First Name:** _______________________________ **Middle Initial:**_____ **Date of Birth:**____________

Preferred to be called: _______________________________

Mailing Address: ____ **City, State, Zip:** ____

Cell Phone:________________________________**Work Phone:**_______________________________**Home Phone:**______________________________

Email:___________________________________ **SS#:**____________________________________

Insurance Information

Primary Insurance Company: ____**Address:** ____

City:_____________________________ **State:**___________ **Zip:**_____________**Phone:**___________________**Relation to Patient:**________________

Policy Holder Name:____ **Birth Date:**________________ **Members ID #:**_____________________________

Employer Name:____**Group # or Policy #:**____

Secondary Insurance Company:____ **Address:** ____

City:_____________________________**State:**___________ **Zip:**_____________**Phone:**___________________**Relation to Patient:**________________

Policy Holder Name:____ **Birth Date:**________________ **Members ID #:**_____________________________

Employer Name:____**Group # or Policy #:**____

Dental Health History

Name of your former Dentist :______________________ How long since you were last seen? ______________________

What prompted you to seek dental care at this time?____

Are you having discomfort at this time? If so describe:____

Is keeping your teeth important to you? [Y] [N] If yes, why?______________________________________

On a scale of 1-10, 10 being the best, where would you rate your smile?______________

On a scale of 1-10, 10 being the best, where would you rate your oral health?__________

Have you experienced any of the following problems:

[Y] [N] Bleeding Gums

[Y] [N] Have you or your parents suffer(ed) from gum disease?

[Y] [N] Bad Breath or sour taste in mouth

[Y] [N] Burning sensation in mouth

[Y] [N] Soreness in jaw

[Y] [N] Is it hard for you to open wide?

[Y] [N] Clicking, popping or other noises in jaw

[Y] [N] Ever been injured in your mouth or head?

[Y] [N] Do you or your parents wear dentures/partials?

[Y] [N] Oral surgery of any kind?

[Y] [N] Sensitivity to Hot & Cold

[Y] [N] Problems when you chew

[Y] [N] Food Catching between teeth

[Y] [N] Clenching or Grinding your teeth

[Y] [N] Easily gag

[Y] [N] Do you feel your teeth fit together well

[Y] [N] Stiff neck/throat muscles

[Y] [N] Do you smoke or chew tobacco?

[Y] [N] Did you ever wear braces?

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?__________________

____

Do you snore or even been told you snore? [Y] [N] Have you ever been diagnosed with sleep apnea? [Y] [N]

Have you ever been treated for sleep apnea? If yes, please explain______________________________________

If you could change anything about your smile which of the following would you want? (mark all that apply)

[Y] [N] Whiter

[Y] [N] Replace missing teeth

[Y] [N] Remove stains/spots on teeth

[Y] [N] Straighter

[Y] [N] Close Space or spaces

[Y] [N] Replace old crowns

[Y] [N] Less Gum showing

[Y] [N] Replace Chipped teeth

[Y] [N] Remove silver filling(s)

[Y] [N] Replace old plastic filling(s)

[Y] [N] Reshape/resize my teeth

Please circle the following which are important to you when making your dental health decision?

Convenience	Appearance	Comfort	Quality of care
Finances	Time	Fear or Anxiety	Detailed treatment explanations
What insurance covers	Health	Relationship with Dental Team	Technology

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?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other If yes, please explain: ______________________

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

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 ______________

FINANCIAL & APPOINTMENT AGREEMENT

Alpine Family Dental
101 Westview Park Place
Kalispell, MT 59901
406-752-1107

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our Financial Coordinators for an estimated cost prior to treatment. We realize that every person's financial situation is different. We offer the following payment options:

1. Cash, Check, Visa, Master Card, Discover, and AMEX
   - A $30 service charge will be assessed on all returned checks.

2. Flexible payment plans upon approval with CareCredit. Approval must be received prior to reserving treatment appointment.

Patients Covered by Insurance:

Our office is considered **out of network** with dental insurance companies. Some policies do not allow for out of network coverage. Some dental policies there is no difference or a minimal differences for seeing an out of network provider. It depends on your insurance plan. **If your insurance reimburses you directly you will be asked to pay for all visits in full.**

It is your responsibility to know your policy. As a **courtesy** to our patients, we will prepare and submit dental claims and assist in making collection from insurance companies. We can generally **estimate** your benefits with reasonable accuracy; however, you will be held fully responsible for any amount not paid by insurance regardless of the reason they refuse payment. **Our office recommends and provides dental care to help you achieve optimal dental health, not whether your insurance company covers it.** Please note your insurance policy is an agreement between yourself and the insurance company; therefore, all charges are your responsibility.

Patient portions are due in full at the time services are rendered. For patient portions over $300, we offer a prepayment discount of 5% with check/cash or 3% with a card if paid in full at the time appointment is reserved. Care Credit financing is also available with 6 months no interest for charges over $200; no pre payment discount applied with Care Credit. A refund on your account will be given if applicable, less any prepayment discounts.

• I authorize all benefits be payable to Gregory D. Eller, DMD DBA Alpine Family Dental, and I agree to release any and all information necessary for the dental office to process claims and release information and payment of my dental benefits directly to this practice.

• I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I authorize the use of my signature on all insurance submissions.

• Additionally, by signing this form I authorize Gregory D. Eller, DMD DBA Alpine Family Dental to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

• I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collection fee, legal fees, and any other charges incurred to collect this account. I grant my permission to you to telephone me at home or work to discuss matters related to this form.

• I have read and understand the above financial and office policy agreement and have had an opportunity to have my questions answered. I understand that by signing this document, I agree to all the terms contained within it.

Print Patient Name:____

Signature of Patient and/or Legal Guardian: ____________________________________ Date: _____/_____/________

Relationship to Patient: ____

Appointment Policy

Our time is valuable and so is yours. Please understand that we reserve chair time just for you when you reserve an appointment. In an effort to continually provide quality service please keep your reserved time as scheduled. We require 48 hours notice from you to change/cancel your reservation. Please remember scheduled appointments are time reserved specifically for you with our providers. Your 48-hour notice allows us to offer your time to other patients awaiting dental treatment. If you arrive late to an appointment, we may not be able to see you that day and your tardiness will be considered a short notice cancellation. After two (2) consecutive broken or late appointments, our office will require a 100% non refundable prepayment for future reservations, in addition to your financial responsibilities outlined above. In order for our office to properly manage your dental care needs current information is imperative. Please keep your records up to date by informing us of any changes to your account. This would include but not be limited to: name, address, phone numbers, email address, employer, insurance and all medical/health history. Appointment reminders are solely a courtesy.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT AND APPOINTMENT POLICY.

Signature of Patient and/or Legal Guardian: ____________________________________ Date: _____/_____/________

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please let us know.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. If so we will not be allowed to process your insurance claims.
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Alpine Family Dental (Gregory D. Eller, DMD PC). A copy of the signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Print Patient Name:____

Signature of Patient and/or Legal Guardian: ____________________________________ Date: _____/_____/________

Relationship to Patient: ____

Please list any other people who are allowed access to your PHI, this may include spouse, partner, step parents, parents (when patient is over age 18 but parents carry insurance), grandparents, care takers or any other individual.

Name:____ **Relation:**____________________________

Name:____ **Relation:**____________________________

Name:____ **Relation:**____________________________

Name:____ **Relation:**____________________________

OFFICE USE ONLY: As privacy officer, I attempted to obtain the patient's (or legal guardians) signature on this acknowledgement but was not able to because
It was an emergency treatment I could not communicate with the patient The patient refused to sign The patient was unable to sign Other
Signature of Privacy Officer: ______________________________________