

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] Sensitivity to Hot & Cold |
| [Y] [N] Have you or your parents suffer(ed) from gum disease? | [Y] [N] Problems when you chew |
| [Y] [N] Bad Breath or sour taste in mouth | [Y] [N] Food Catching between teeth |
| [Y] [N] Burning sensation in mouth | [Y] [N] Clenching or Grinding your teeth |
| [Y] [N] Soreness in jaw | [Y] [N] Easily gag |
| [Y] [N] Is it hard for you to open wide? | [Y] [N] Do you feel your teeth fit together well |
| [Y] [N] Clicking, popping or other noises in jaw | [Y] [N] Stiff neck/throat muscles |
| [Y] [N] Ever been injured in your mouth or head? | [Y] [N] Do you smoke or chew tobacco? |
| [Y] [N] Do you or your parents wear dentures/partials? | [Y] [N] Did you ever wear braces? |
| [Y] [N] Oral surgery of any kind? | |

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] Close Space or spaces | [Y] [N] Remove silver filling(s) |
| [Y] [N] Replace missing teeth | [Y] [N] Replace old crowns | [Y] [N] Replace old plastic filling(s) |
| [Y] [N] Remove stains/spots on teeth | [Y] [N] Less Gum showing | [Y] [N] Reshape/resize my teeth |
| [Y] [N] Straighter | [Y] [N] Replace Chipped 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?
- | | | | | |
|-------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| | | | | <input type="checkbox"/> Venereal Disease |
| | | | | <input type="checkbox"/> 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: _____