purpleplum
DENTISTRY
Anita Kianimanesh, DMD

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

_____ _____

Signature Date

800 W Broad Street Suite 207 Falls Church, VA 22046 O: (703) 998-4244 F: (703) 998-4246 www.purpleplumdentistry.com

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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_____

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PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

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

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID:_____ Pref. Dentist: _____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg.: _____

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

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

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

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

Have you ever had orthodontic treatment? ☐ Yes ☐ No (Invisalign/Candid/or any other)

If yes, when? _____

Have you ever had periodontal disease(gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? If yes, when? ☐ Yes ☐ No _____

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)*

☐ Teeth Whitening
☐ Orthodontic treatment
☐ Veneers
☐ Tooth-colored fillings
☐ Dental implants
☐ How to prevent periodontal disease
☐ At-home oral hygiene care
☐ Periodontal treatment during pregnancy
☐ Oral hygiene care for infants and toddlers

Patient Interest Questionnaire

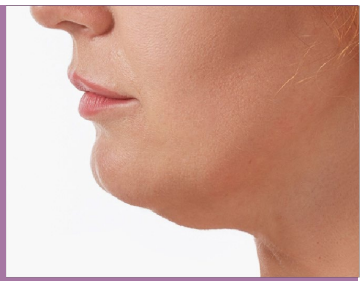
Name: Age: Date: / /

Please indicate any areas of concern for you

Check all that apply.

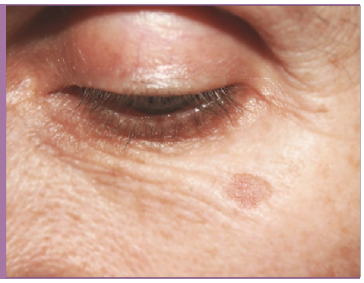
- ☐ Forehead Lines

- ☐ Double chin



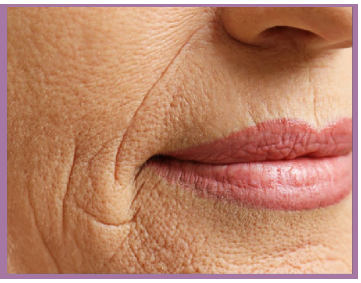
- ☐ Frown Lines

- ☐ Skin appearance and texture

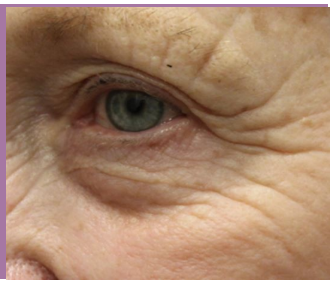


- ☐ Crow's feet lines

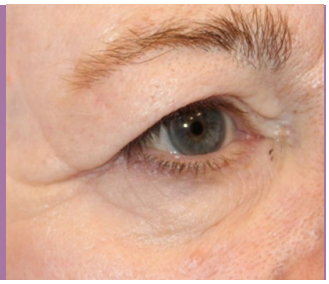
- ☐ Lines and wrinkles around nose and mouth



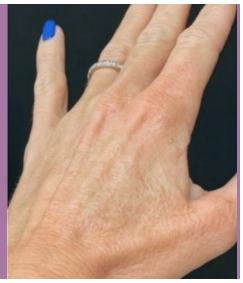
- ☐ Wrinkles around eyes



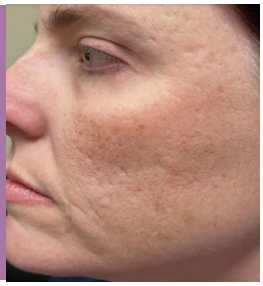
- ☐ Excess upper eyelids



- ☐ Hands & Scars



- ☐ Acne Scars



Patient Interest Questionnaire

Share how you see yourself

I feel like I look like --→ -→

- ☐ Sad
- ☐ Angry
- ☐ Tired
- ☐ Less lively
- ☐ Fearful
- ☐ Saggy
- ☐ Pained
- ☐ Less desirable
- ☐ Older than I feel
- ☐ Other _____

Evaluate concerns and aesthetic goals to customize each consultation

Patient name: Next appointment date: / /

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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 $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)

FREE PARKING IN BUILDING

- I-395 Washington
- Follow I-395 S to VA-110 N in Arlington. Take exit 8B from I-395 S
- Get on I-66 W
  Follow I-66 W to VA-7 E/Leesburg Pike in Idylwood. Take exit 66A from I-66 W

Drive from I-495 N to West Falls Church. Take exit 50A-50B from I-495 N
Head northeast on I-395 N
Use the right 2 lanes to take exit 170B to merge onto I-495 N toward Tysons Corner
Keep right at the fork to stay on I-495 N
Take exit 50A-50B to merge onto US-50 E/Arlington Blvd toward Arlington
Continue on US-50 E/Arlington Blvd. Take Marshall St to W Broad St in Falls Church
Merge onto US-50 E/Arlington Blvd
Turn left onto Marshall St
Continue onto S Oak St
Turn left onto W Broad St