Purple Plum Dentistry
DENTAL/MEDICALHISTORY FORM

703-998-4244
www.purpleplumdentistry.com

Last Name: _____First name: _____Middle Initial: _____Male ☐ Female ☐ Other ☐
Street Address: _____City_____State_____ Zip: _____
Date of Birth: _____ Social Security #:_____ Phone:_____
Email:_____ How do you prefer we contact you? _____
Occupation: _____ Dental Insurance: _____ Dental Id. _____
Emergency contact: _____ Relationship: _____Phone: _____
Previous Dentist Name: _____ City: _____ State: _____ Phone: _____

Dental History

Question	Yes	No	Question	Yes	No
Do your gums bleed when you brush or floss?			Do you experience frequent ulcers in your mouth?		
Are your teeth sensitive to hot, cold, sweets, or pressure?			Do you currently have any sores or ulcers in your mouth?		
Does food or floss catch between your teeth?			Do you participate in energetic sports or activities?		
Is your mouth often dry?			Do you grind or clench your teeth?		
Have you had periodontal (gum) treatment?			Do you wear dentures or partial dentures?		
Have you had orthodontic treatment (braces/Invisalign)?			Do you wear or have a night guard?		
Have you had serious injury to your head or mouth?			Are you a mouth breather?		
Do you have clicking, Popping, or other discomfort in your jaw?			Date of your last dental Exam?	/ /	
Have you had any problems related to dental treatment?			Date of your last dental radiographs(x-rays)	/ /	
Are you currently experiencing dental pain or discomfort?			How often do you brush your teeth per day?		
Have you been diagnosed with TMJ/TMD			How often do you floss your teeth per day?		
Have you been diagnosed with Sleep Apnea? When:			Do you use mouth wash?		

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Question	Yes	No	Question	Yes
Do you have sensitivity to hot/cold? If yes, explain _____			Are you having pain/sensitivity when chewing? If yes, explain_____	
Have you been anxious about Dental treatment? If yes, explain: _____ _____			Have you had problems with prior dental treatment? If yes, explain: _____ _____	

What is the reason for your visit today?_____

Medical History

	Question	Yes	No	If Yes, please explain
A.	Are you under a physician's care now?			
B.	Have you ever been hospitalized or had a major operation?			
C	Have you ever had a serious head or neck injury?			
D.	Are you taking any medications, pills, or drugs?			
E.	Do you take, or have you taken, Phen-Fen or Redux?			
F.	Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing bisphosphonates?			
G.	Are you on a special diet?			
H.	Do you use any tobacco products?			
I.	Do you use any controlled substances?			
J.	Do you Vape or use E-cigarettes?			
K.	Do you use any forms of Marijuana, Pot, Weed or Cannabis?			
L.	Have you used any tobacco products, controlled substances, vape or any forms or marijuana in the past?			

Other:

_____

_____

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Medications

Please list any/all prescriptionandover-the-countermedicinesthatyouarecurrentlytaking.Includevitamins, natural medicines, supplements, or remedies. Please include dosages and frequency of use.

Prescription		Over-the-counter	
Name of medication	Dose	Product name	Frequency of use

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

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV positive			Cortisone medicine			Hemophilia			Radiation treatment		
Alzheimer's disease			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug addiction			Hepatitis B or C			Renal dialysis		
Anemia			Easily winded			Herpes			Rheumatic fever		
Angina			Emphysema			High blood pressure			Rheumatism		
Arthritis/Gout			Epilepsy or seizures			High cholesterol			Scarlet fever		
Artificial heart valve			Excessive bleeding			Hives or rash			Shingles		
Artificial joint			Excessive thirst			Hypoglycemia			Sickle cell disease		
Asthma			Fainting or dizziness			Irregular heartbeat			Sinus trouble		
Blood disease			Frequent cough			Kidney problems			Spinal bifida		
Blood transfusion			Frequent diarrhea			Leukemia			Stomach/Intestinal disease		
Breathing problems			Frequent headaches			Liver disease			Stroke		
Bruise easily			Genital herpes			Low blood pressure			Swelling of limbs		
Cancer			Glaucoma			Lung disease			Thyroid disease		
Chemotherapy			Hay fever			Mitral valve prolapsed			Tonsillitis		
Chest pains			Heart attack/Failure			Osteoporosis			Tuberculosis		
Cold sores/Fever blisters			Heart murmur			Pain in jaw joints			Tumors or growths		

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	Yes	No		Yes	No		Yes	No		Yes	No
Congenital heart disorder			Heart pacemaker			Parathyroid disease			Ulcers		
Convulsions			Heart trouble/Disease			Psychiatric care			Venereal disease		
Have you ever had any serious illness above?			If Yes, Please explain:_____						Yellow Jaundice Sleep Apnea		

Additional questions for women.

Question	Yes	No
Are you pregnant or trying to get pregnant?		
Are you taking oral contraceptives?		
Are you nursing?		

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs

☐ other; please explain: _____

Physician's name:_____City:_____State:_____ Phone: _____

I understand the importance of complete and truthful medical and dental information and that incorrect information could pose a serious threat to my health. To the best of my knowledge the answers to the preceding questions are true and correct. I will not hold Purple Plum Dentistry (PPD) or any person who provides dental Hygiene or dental services responsible for any actions that they take or do not take because of any errors or omissions that I may have made in the completion of this form. I consent to the release of medical/dental information to my dentist, physician, or other healthcare professional if requested.

Further, if I ever have any change in my health, or if my medications change, I will inform Purple Plum Dentistry in my next appointment. I hereby grant permission to be treated by Purple Plum Dentistry.

_____ _____
Patient Name Date

_____ _____
Patient Signature *Date*

_____ _____
Signature of Dentist *Date*

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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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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

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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)