Monica M. Pierpan, DDS, PA ~~ Henry J. Pierpan, DDS
U.S. Hwy. 17 N., Ste #10 Hampstead, NC 28443

Patient Information

Patient Name: _____ Date: _____
Last *First* *MI*
Male___ Female ___ Married ___ Single ___ Child ___ Other _____

Social Security Number _____ Birth Date _____ Email address _____

Phone Numbers (Home) _____ (work) _____ (cell) _____

Preferred # to confirm appts _____ Driver's License #_____ State ____

Address _____
Street *City* *State* *Zip Code*

Date of Last Dental Visit _____Reason for today's visit _____

What form of payment will you be using today? Cash _____ Check _____ MC/VISA ____ Carecredit ____

Have you ever had any of the following? Please check those that apply:

Aids/HIV _____	Glaucoma _____	Pregnancy ____	Penicillin Allergy ____
Allergies _____	Growths _____	Due Date: _____	OTHER: _____
_____	Hay Fever _____	Radiation Treatment ____	_____
Anemia _____	Head Injuries ___	Respiratory Problems ___	_____
Arthritis _____	Heart Disease ____	Rheumatic Fever _____	LIST MEDICATIONS: _____
Artificial Joints _____	Heart Murmur ____	Rheumatism _____	_____
Asthma _____	Hepatitis _____	Sinus-Problems _____	_____
Blood Disease _____	High Blood Pressure ____	Stomach Problems _____	_____
Cancer _____	Jaundice _____	Stroke _____	_____
Diabetes _____	Kidney Disease _____	Tuberculosis _____	_____
Dizziness _____	Liver Disease _____	Tumors _____	_____
Epilepsy _____	Mental Disorders _____	Ulcers _____	_____
Excessive Bleeding ___	Nervous Disorders _____	Venereal Disease _____	_____
Fainting _____	Pacemaker _____	Codeine Allergy _____	_____

Hobbies _____

*Have you been admitted to a hospital or needed emergency care during the past two years? Yes ____ No ____
If yes, please explain _____

*Name of physician _____ Phone: _____

*Are you now under routine care of a physician? Yes ____ No ____
If yes, please explain_____

*Do you have any health problems that need further clarification: Yes ____ No ____
If yes, please explain _____

FAMILY INFORMATION

Spouses Name _____
____ Male ___Female

Phone Numbers (home) _____ (work) _____ (cell) _____

Address (if different from address on front) _____
Physical address *City* *State* *Zip*

Names of children (if applicable)_____

To Whom may we thank for referring you to our practice? _____

EMERGENCY INFORMATION (If changed)

Emergency contact #1_____ Phone _____
Name/relationship to patient

_____
Address *City* *State* *Zip Code*

EMPLOYMENT INFORMATION (If changed)
(Person responsible for payment)

Employer Name _____ Occupation _____

Address _____
Street *City* *State* *Zip Code*

INSURANCE INFORMATION (If changed)

Name of Insured _____ Is insured a patient? Yes____ No ____
Last *First* *MI*

Insured's Date of Birth _____SSN# _____ Group #_____

Insured's Address (if different from address on front) _____

_____

Patient's relationship to insured: Self ____ Spouse ____ Child ____ Other _____

Insurance Plan Name and Address: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. At anytime this office may run a credit report in order to arrange financial agreements.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to Patient

_____ _____ _____
Signature of guarantor of payment/responsible party Date Relationship to Patient

Privacy Policy for Monica M. Pierpan, DDS, PA

We are committed to maintaining the confidentiality, integrity and security of personal health information entrusted to us by current and prospective patients. We want you to know how we protect your information and how we use it to better serve your needs. Please take a moment to review our privacy policy.

Your Right to Know

You have a right to know what we do with the personal and confidential information we collect about you in the course of treating your dental health needs and administering the necessary financial and insurance documents for your services. Because we value the integrity of our patient relationships, we want to assure you that we are properly safeguarding this important information.

Personal Information We Collect

We need accurate, current health and insurance information about you so that we can determine your coverage and provide dental treatment to meet your specific needs. We collect personal information that you provide to us on a medical history form, personal information form, other forms, and in interviews. In addition, we maintain information about your care with us in your chart, and on our computer system. We may obtain additional information from third parties such as other health care providers, pharmacies, insurance companies, and consumer reporting agencies.

Information We May Disclose

We may share your personal financial and health information on a confidential basis only with authorized employees, representatives and third parties whose services are required to assure the highest level of service to you.

We may contact you to provide appointment reminders. We may use an/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment. We may contact you with information about treatment, services, products or health care providers.

Protection of Your Information

Reasonable care will be taken to keep pertinent records current, complete and accurate. If you see any inaccuracy in your statements or in any other communication from us, we would appreciate your assistance in making corrections by contacting us.

We will protect all information collected about you, and we will restrict access to non-public personal information by maintaining physical, electronic, and procedural safeguards. We will restrict access to protected data only to individuals who must use it in the performance of their job-related duties.

Above all, we value your trust and your confidence in our ability to manage and protect your important personal information.

If you have any questions or concerns about our privacy policy, please speak to our office manager.

Thank you for choosing our office to serve your dental needs. We value you as a patient and appreciate the opportunity to serve you.

Please sign below to inform us that you have read and understand our new policy so that we may keep a copy in your chart.

Patient Guardian Signature

Financial Policy for Monica M. Pierpan, DDS, PA

Welcome to the Pierpan Family Dentistry office. We are committed to providing you with the best possible care. Our office hours are Monday, Tuesday, and Friday from 8:00 am- 5 pm., Wednesday and Thursday from 9:00 a.m. - 5:00 p.m. All appointments are considered a reservation of the time set aside for you. We will give you a courtesy call prior to your appointment.

Payment is expected at time of service. If you have insurance, we will accept assignment with most insurance companies. This means we will gladly file your claim with your insurance company after verification of coverage. You will be expected to pay your portion of services at the time of visit, including but not limited to, co-payments, percentages, and deductibles. If for any reason your insurance company denies a claim the balance is billable to the patient in full. In the situation of a divorce, the parent who signs the financial policy is the responsible party on the account regardless of who the insurance subscriber may be. We accept cash, checks, MasterCard, Visa and Discover. If you are unable to render payment at the time of service we will gladly reschedule your appointment. We will estimate as closely as possible your coverage, but until we actually receive payment form the insurance company, it is just an estimate. We will assist you in dealing with the insurance company, but the ultimate responsibility lies with you. We do not file secondary insurance. After 45 days, the balance will be due from you in full. If we are unable to verify coverage, you will be expected to pay for the visit in full.

If more than one family member is a patient, then they will be grouped under one account. If you wish to have a separate account from other family members, please notify the front desk upon signing this form. Family members can only be on separate accounts if they have separate insurance policies.

A service charge of 1 ½ % per month (18% per annum) on the unpaid
balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. At any time during treatment, we may contact credit bureau with information regarding this account.

Returned checks will be charges $36.00. We will not attempt to redeposit more than once. Missed appointments, cancellations, or reschedules with less than 48hr. notice are subject to a $50.00 charge.

I have read the above policy, understand my responsibilities, and agree to these terms.

Signed _____ Date _____