PIERPAN
Dental Excellence

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 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

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:

Section 3

Emergency Contact

INS Verfied On / By

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: Rem. Deduct:

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: Rem. Deduct:

Henry J. Pierpan, III, DDS

Eaglesoft Medical History(Copy)(Copy)

Date 5/7/2019

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Additional Questions:

Do you Snore?	◯ Yes ◯ No	If yes
Have you ever been diagnosed with Sleep Apnea?	◯ Yes ◯ No	If yes
Do you sleep with a CPAP machine?	◯ Yes ◯ No	If yes

Women: Are you...

Pregnant/Trying to get pregnant?	◯ Yes ◯ No	Nursing?	◯ Yes ◯ No	Taking oral contraceptives?	◯ Yes ◯ No

Are you allergic to any of the following?

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

Other Allergies? Please List: ◯ Yes ◯ No If yes

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	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Heart Stents	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X

Date:_____

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Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

(Initial below)

I _____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging

____ Email

I would like to receive:

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

INSERT YOUR OFFICE NAME|PHONE NUMBER|OFFICE EMAIL ADDRESS:

Patient Signature:_____ Date:_____

PIERPAN
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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

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Dental Excellence

APPOINTMENT SCHEDULING POLICY

When you schedule an appointment in our office, we consider this appointment a reservation of chair time and expect that you will be recording this appointment date and time on you schedule. As a courtesy, we make every effort to remind patients of their appointment via postcard, email, text messaging, and phone. We do require that you respond to these calls by letting us know that you will attend your appointment. If we do not hear from you to confirm your appointment within 48 hrs of the scheduled time, we reserve the right to schedule another patient at that given date and time.

If you must change your appointment, we require at least 48 hour notice to avoid a possible cancellation fee. If commitments for appointments are frequently broken, a non-refundable reservation fee may be required to continue to schedule appointments in our office. When appointment times are lost due to last-minute cancellation, it delays your needed treatment and also prevents other patients from using that appointment time for their needed treatment.

Thank you in advance for respecting our scheduling polices. If you have any questions about scheduling, we would be glad to answer it.

FAMILY MEMBERS IN DENTAL TREATMENT ROOM POLICY

In order to provide the highest quality of care safely and efficiently to our dental patients, all family members and friends are required to remain in the waiting area while dental treatment services are being rendered. This policy will help our dental team ensure safety, infection control and patient confidentiality.

PARENT(S) OF MINOR CHILDREN

Experts in the field of pediatric dentistry universally agree that children are much more cooperative and attentive when parents are not present during dental treatment. In the event your presence is required in the dental operatory, you will be asked to join. With an especially resistant or frightened child, referral to a specialist might be necessary. Refusal to adhere to these policies could result in rescheduling until the parent feels that their child can handle routine dental care on their own.

I have read and understand the policies noted above for Pierpan Dental Excellence.

_____ _____

(Patient Signature) (Date)

Henry Pierpan, DDS * Monica Pierpan, DDS

20 Office Park Drive* Jacksonville, NC 28546* Tel:910-353-3551*www.pierpandentistry.com

PIERPAN
Dental Excellence

Financial Policy

Welcome to Pierpan Dental Excellence. We are committed to providing you with the best possible care. Our office hours are Tuesday - Friday, 8:00 a.m. to 5:00 p.m. All appointments are considered a reservation of the time set aside for you. We will do our utmost to schedule your visits at times that are convenient. We will assist you by giving you a courtesy call prior your appointment. In return we ask that you do the same and call to confirm all appointments to honor your reservation. Appointments that are unconfirmed within 48 hours prior the appointment may lead to cancellation.

Payment is expected at time of service. If you have insurance, we will accept assignment with most insurance companies 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 denies a claim, the balance will be billed to you 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, Care Credit, Mastercard, and Visa. Checks are only accepted for patients with established credit history. If you are unable to render payment at the time of service, we will be happy to reschedule your appointment or discuss financial arrangements prior being seated. We will estimate as closely as possible to your coverage, but until we actually receive payment from the insurance company, it is just an estimate. We will assist you in dealing with your insurance company, but ultimate responsibility lies with you. We do not file secondary insurances, but will assist you as much as we can in the process. After 45 days from the date of service, 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 member can only be on separate accounts if they have separate insurance policies.

A service charge of 1 1/2% 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. At any time during treatment, we may contact a credit bureau with information regarding this account.

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

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

Signed_____ Date_____

Henry Pierpan, DDS * Monica Pierpan, DDS

20 Office Park Drive* Jacksonville, NC 28546* Tel:910-353-3551*www.pierpandentistry.com

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Henry Pierpan, DDS * Monica Pierpan, DDS

20 Office Park Drive* Jacksonville, NC 28546* Tel:910-353-3551*www.pierpandentistry.com

Monica M Pierpan, DDS, PA
Henry J. Pierpan, DDS, PA

Name:
Date:
BP:

DENTAL HEALTH HISTORY

How did you hear about our practice?
□ YELP □ GOOGLE □ Family/Friend_____ □ Insurance □ Other:_____

When was your last dental visit?
And what was that visit for?

Are you having any dental problems that require immediate attention?

Do you smoke or use tobacco products?
What age did you start?

Do any of the following cause tooth discomfort or pain? If so, note which area of your mouth.
Hot
Cold
Sweets
Chewing

How often do you brush your teeth?
Floss?
Waterpick?

Do your gums bleed or feel tender or swollen?
Have you had any periodontal treatment (treatment for gum disease)?

Do you clench or grind your teeth?
Do your jaws ever feel tired or ache?
Click or Pop?
Headaches?

Have you ever had orthodontic treatment (braces)?
When?
Where?

Have you ever been diagnosed with sleep related breathing problems?

Do you snore while sleeping?

How do you feel about the appearance of your smile?

Have you ever had any unpleasant dental experiences?

_____

(Patient Signature) (Date)