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

US. 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 ____

H**ave 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