Brittany Pierpont, DDS

Today's Date: ______________________

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. Preferred Name: ______________________________

Patient Full Name: ____ Date of Birth: _________________

Guardian Name (if patient is a minor): ____________________________ Relationship: ________________

Marital Status (circle): Single Married Other: ___________ Gender: Male Female

Driver's License #: _____________________________________ SS#: ____________________________

Address: ____
Street City State Zip

Home Ph#: ____________________ Cell#:_____________________ Email: _______________________

DENTAL INSURANCE INFORMATION

Subscriber/Policy Holder Name: _________________________ Relationship to Patient: _______________

Subscriber/Policy Holder DOB: _________________ Subscriber/Policy Holder SS#: ___________________

Policy/Member ID#: _____________________________ Group/Plan#: _____________________________

Employer/Group Name: ____

Insurance Carrier/Company: ________________________ Insurance Ph#: ________________________

EMERGENCY CONTACT:

Name: ______________________________ Ph#: ______________________ Relationship: _____________

PREFERRED PHARMACY:

Pharmacy Name: _________________________________ Pharmacy Ph#: ___________________________

Pharmacy Address: ____

How did you hear about our office? If referred, who may we thank? __________________________________

Patient Name: ____________________________________ DOB: ______________________

DENTAL HISTORY

When was the last time you saw a dentist? _____________ Name of previous dentist? __________________

Have you ever been told you have periodontal disease? ____

Do you experience jaw pain? __________________ Do you clench or grind your teeth? __________________

Do you get frequent headaches? YES NO Are you happy with your smile? ____________________

What is the reason for your visit today? ____

MEDICAL HISTORY

Are you currently under a physician's care for ongoing treatment? YES NO For what? __________________

Physician's Name and Ph#: ________________________________ Date of last visit? _____________________

Have you had any major surgery? YES NO Please explain: _______________________________________
____

Are you currently taking any medication? YES NO If yes, please list all medications: _____________________
____

Are you allergic to any of the following (circle): Aspirin Penicillin Codeine Latex
Local Anesthetics Other: ___________________________

Have you ever been told that you need to premedicate by your physician? YES NO
Do you use tobacco products: YES NO

WOMEN ONLY: Are you pregnant? YES NO Expected due date: ________________
Are you trying to get pregnant? YES NO Nursing? YES NO

HEALTH CONDITIONS (Circle all that apply)

Acid Reflux/Gerd	Chest Pain	Heart Attach/Failure	Lung Disease
AIDS/HIV Positive	Congenital Heart Disorder	Heart Murmur	Mitral Valve Prolapse
Alzheimer	Convulsions	Heart Pacemaker	Osteoporosis
Anaphylaxis	Cortisone Medicine	Heart Trouble/Disease	Pain in Jaw Joints
Anemia	Diabetes	Hemophilia	Psychiatric Care
Angina	Drug Addiction	Hepatitis ( )A ( )B ( )C	Radiation Treatment
Arthritis/Gout	Easily Winded	High Blood Pressure	Rheumatism
Artificial Heart Valve	Emphysema	High Cholesterol	Sinus Trouble
Artificial Joint	Epilepsy/Seizures	Hives or Rash	Spina Bifid
Asthma	Excessive Bleeding	Hypoglycemia	Stomach/Intestinal Issues
Blood Disease	Fainting Spells/Dizziness	Irregular Heartbeat	Stroke
Blood Transfusion	Frequent Headaches	Kidney Problems	Thyroid Disease
Breathing Problems	Genital Herpes	Leukemia	Tonsilitis
Bruise Easily	Glaucoma	Liver Disease	Tuberculosis
Cancer	Hay Fever	Low Blood Pressure	Tumor or Growth
Chemotherapy			

Have you ever had any serious illness not listed above? YES NO Explain: ______________________________
Have you ever taken or currently taking any BLOOD THINNERS? _______________________
Have you ever taken or currently taking a BISPHOSPONATE? __________________________

Signature: ____ Date: ____________________

Brittany Pierpont, DDS

FINANCIAL POLICY AND CONSENT FOR SERVICES

Welcome and thank you for choosing *Pier Dental* for all your dental needs. We are committed to providing you with the highest quality dental care. Please see below for our office policies:

Treatment Plan

We have prepared for you an itemized Treatment Plan that outlines the sequence of dental services to be provided. Due to the nature of dentistry, treatment and fees may change; if this occurs, we will inform you prior to rendering any services.

Insurance Disclaimer

I have been advised that Pier Dental is not an in-network provider for any insurance company, therefore, services provided to me will be considered out-of-network. I understand that my insurance carrier may render payment at a lower rate compared to those considered in-network, and that I am responsible for any balance on my account.

If you have a dental policy that enables you to go to non-providers, we will gladly file assist you by sending in the necessary paperwork for your reimbursement. Most insurance companies will respond within four to six weeks. Please call our office if your insurance company does not send you a payment in the mail after this time frame. Any insurance discrepancy must be reported to the front desk within 6 months of service date to be resolved.

If you have any questions about your insurance coverage, we will be happy to help you discover your dental insurance benefits or you can contact your insurance company or your Employer's Human Resources Department.

Please notify staff if you have changed your address, phone number or insurance coverage, if any.

Please note: There is a $50 fee charged to your account if you fail to cancel an appointment with less than 48 hours notice

Payment is due at the time of service unless prior financial arrangements have been made in advance.

I agree to allow Brittany Pierpont, DDS, LLC and her agents to use the photographs of any portion of my dental treatment for the purpose of teaching and any marketing or advertising medium. At no time will the patient's name, address, or any other patient identifiable information be used in connection with the publication of the photographs of the patient.

I understand and have agreed to the above office policies. I hereby attest that I have given and agreed to provide current personal, demographics, and insurance information and authorize the release of information necessary to fill insurance and/or collection of my account.

____ ________________________

Print Patient Name Date of Birth

____ ________________________

Signature of Patient / Legal Guardian Date

Brittany Pierpont, DDS

HIPAA DISCLOSURE FORM

Patient Name: ___________________________________ Date of Birth: _________________

Authorizing Parent/Guardian: _____________________________ Relationship: ________________

Address: ________________________________ Phone Number: _______________________

________________________________ Alt Phone Number: ____________________

________________________________ Email Address: ________________________

May we identify ourselves over the phone? ☐ YES ☐ NO

May we leave messages? ☐ YES ☐ NO

Do you opt for email correspondence? ☐ YES ☐ NO

I, the patient or authorized parent/guardian, hereby allow Pier Dental and its affiliates to discuss, transfer and/or release my medical and dental information such as appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, prescriptions, etc.… via postal mail, telephone, fax, and/or email to the following persons:

Name: _______________________________ DOB: _______________ Relationship: ___________

Name: _______________________________ DOB: _______________ Relationship: ___________

Name: _______________________________ DOB: _______________ Relationship: ___________

Name: _______________________________ DOB: _______________ Relationship: ___________