WELCOME TO OUR OFFICE

To aid in providing diagnosis and treatment for your dental needs. please fill out completely this confidential questionnaire.

Date: _____

PATIENT NAME: _____ **Birth Date:** _____

Address: _____ **Social Security #:** _____

Age:_____ **Sex:**_____ **Marital Status:**_____

_____ **Home Phone:**_____

City State Zip **Business Phone:** _____

Cell Phone: _____

Spouse Info: _____ **Email:** _____

Please, who may we thank for referring you to our office: _____ **Occupation:** _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Employer: _____

Relationship to patient: _____ Address: _____

Social Security No. _____ Birthdate:_____

Dental Insurance Carrier: 1. _____ City, State, Zip, Phone, ID# _____

2. _____ City, State, Zip, Phone, ID# _____

HEALTH HISTORY

Name of physician _____ Phone _____

How is your general health? (please circle) Excellent Good Fair Poor

Do you have, or have you ever had, any of the following (**please circle yes or no**)

yes no **Heart Disease / Chest Pain / Pacemaker**	yes no **Diabetes**	yes no **Tumor History**	yes no **AIDS / HIV Positive**
yes no **HTN / High Blood Pressure**	yes no **Liver / Kidney Disease**	yes no **Radiation Treatment / Chemotherapy**	yes no **Prolonged Bleeding**
yes no **Rheumatic Fever**	yes no **Stroke**	yes no **Venereal Disease**	yes no **Blood Disorders / Anemia**
yes no **Heart Murmur / Mitral Valve Prolapse**	yes no **Epilepsy**	yes no **Sinus / Allergies**	yes no **Glaucoma**
yes no **Prosthetic Joint Replacement**	yes no **Fainting**	yes no **Ulcers / Colitis**	yes no **Thyroid**
yes no **Hepatitis / Jaundice**	yes no **Psychiatric Treatment**	yes no **Tuberculosis**	yes no **Recreational Drugs**
yes no **Bisphosphonate Drug Therapy**	yes no **Arthritis / Osteoporosis**	yes no **Asthma / Emphysema**	
yes no **Latex Allergy**			

YES NO Are you **allergic** or sensitive to penicillin or **any** other drugs or medicine? Explain _____

YES NO Are you taking medications, birth control, or over the counter medications? (If yes, list) _____

Have you ever been hospitalized and/or had surgery within the last five years? (if YES, please explain)

YES NO _____

Are you under the care of a physician now? Explain _____

YES NO Do you have any disease, condition, or problem not listed above? (If yes, list) _____

YES NO Do you smoke or use smokeless tobacco? _____

YES NO WOMEN: Are you pregnant?_____ Delivery Date_____

HEALTH HISTORY REVIEWED BY: _____ Date:_____

DENTAL HISTORY

YES NO When was your last dental visit?_____ What was done then? _____

YES NO Have you been told you have a gum problem or periodontal disease? _____

YES NO Have there been any complications during previous dental treatment? _____

Previous Dentist: _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

To avoid serious medical complications, I shall tell you of any changes in my health history or medications taken. Payment for dental services shall be made when services are provided, unless other written arrangements have been made.

I understand that this office files insurance claims or assumes current eligibility status merely as a courtesy for patients. Denied or unpaid insurance amounts after sixty (60) days are due directly from the patient; fees billed at certain plan rates are due at regular rates if ineligible at the time of service or if coverage denied. If this is an insurance account, I hereby authorize payment of benefits directly to this dental office and authorize you to release information relating to all treatment or benefits submitted for me or my dependents. My signature on this document authorizes my dentist to submit claims for dental service benefits without obtaining my signature on each and every form to be submitted and understand that I will be bound by this signature as though I had signed each particular claim.

I agree to pay a broken appointment fee if I cancel an appointment without giving at least 24 hours notice & I understand and agree that I am personally responsible for all dental service payments. If payments are not made within sixty (60) days of service, interest on the outstanding balance shall accrue at the rate of 1.5% per month, (18% APR) with a minimum billing fee. I further agree to pay all costs of collection, including reasonable attorney fees if this matter is referred to legal recourse and you prevail.

Authorized signature _____

PATIENT QUESTIONNAIRE

Holly Dental Associates

Welcome to our office. We are delighted that you have chosen us to serve you. We will give you excellent care, and we request that you give us excellent commitment to our policies. Please read carefully the following information:

Office Hours:

Monday	**8:00 a.m. – 5:00 p.m.**
Tuesday	**8:00 a.m. – 5:00 p.m.**
Wednesday	**8:00 a.m. – 5:00 p.m.**
Thursday	**8:00 a.m. – 5:00 p.m.**
Friday	**7:30 a.m. – 2:30 p.m.**

Please call the office for emergency needs.

Commitment To Treatment Policy

We believe that all treatment initiated should be completed. Incomplete treatment leads to problems, complications, misunderstandings, and further disease. Therefore, as a treatment plan is agreed upon and started, it needs to be completed. Repeated failure to initiate recommended treatment can also lead to problems, complications, misunderstandings, and further disease as well.

Commitment To Appointment Policy

An Appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you, and you will be present for that appointment. Our office policy is firm in this regard, and we will not tolerate frequent cancellations, constant short notice changes, or late arrivals. We must have mutual respect for each other's time so that everyone will receive the same quality of care.

- Appointments must be cancelled 24 hours in advance (not to include weekends). A fee of $50.00 will be charged for broken appointments.

Commitment To Financial Arrangement Policy

Your insurance co-pay is required at all visits. Our office accepts cash, check, Visa/MC and we also have a Care Credit dental financial plan available upon qualification. You must bring your insurance card with you on your first visit and if your insurance changes at any time.

Dental Insurance

Your insurance plan is an agreement between you and your insurance company. Please be aware that your charges here are your responsibility. As a courtesy, we will file your insurance, but you are ultimately responsible for your entire account.

- We will expect you to take care of your charges if after 60 days your insurance has not paid.
- Your deductible should be paid at your first visit. Any out-of-pocket portion not paid by insurance should be paid at the time the service is rendered.

Miscellaneous

- An 18 APR finance charge will be required on the unpaid balance after 30 days.
- The patient and all Guarantors, Guardians, or Parents agree to pay reasonable attorney fees and collection fees incurred in the collection of outstanding balances.
- There will be a $20.00 service charge on all returned checks.

Our professional services are rendered, time is spent, and charges are made to the patient. By signing below, you are indicating that you understand what we are requesting of you in the above areas and that you agree to fulfill your treatment, appointment, and financial commitments.

_____ _____

Patient or Responsible Party: Date:

Holly Dental Associates

CONSENT TO TAKE X-RAYS

To fully accomplish a complete initial exam, current x-rays are required. There are conditions that cannot be seen without x-rays, such as decay between teeth, gum disease, bone lesions, etc. It is important to be aware of all existing conditions as we establish the new relationship between dentist and patient. We at Holly Dental Associates take this relationship very seriously and must have this information to understand how to help the patient restore and maintain excellent oral health. If the patient has not supplied current x-rays, they will be taken during the first visit.

I agree to allow Holly Dental Associates to take necessary x-rays for my exam to allow for a full and proper diagnosis. I understand that insurance may or may not cover these x-rays, and I accept responsibility for any amount not covered by insurance.

Signature: _____

Date: _____

Holly Dental Associates

Landis C. Scholes, D.D.S. Kurt E. Nielsen, D.D.S.

8010 S. Holly St. Suite 100, Centennial CO 80122

303-694-6400 frontdesk@hollydental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I _____, have received 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:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please Specify)

_____

_____

_____

HOLLY DENTAL ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain in the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notie while it is in effect. This Notice takes effect April 1. 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notie available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and discuss health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your persona representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object o such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not us your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to loo at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be no charge per page, no charge for staff time to locate and copy your health information, and no charge for postage if you want the copies mailed to you. If you request an alternative format, w will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations, **you must make your request in writing.** Your request must specify the alternative mans or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: MICHELLE CLIFTON GONZALES
Telephone: (303) 694-6400 Fax: (303) 694-0557
Address: 8010 S HOLLY SUITE 100
LITTLETON CO 80122