HEALTH QUESTIONNAIRE

Today's Date	Patient's Name	Birth date	Chart# (office use)
___/___/___	____	___/___/____	________________

Name of person completing form (if different from patient) and relation to patient: ______________________________

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

**PLEASE ANSWER BY CIRCLING YES (Y) OR NOT (N) FOR EACH INDIVIDUAL QUESTION. **

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year?.. Y N
3. Date of last check up by physician: ____
4. Are you currently under a physician's care .... Y N
   If so, what for? ____
   Treating Physician's Name ____
5. Have you ever had any serious illness, operations, or hospitalizations?.. Y N
   If so, describe and give approximate dates: ____
   ____
6. Have you ever had intravenous sedation or general anesthesia?.. Y N
   Were there any adverse effects?.. Y N
7. Do you generally tolerate dental treatment well? .... Y N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Heart disease that was detected at birth? .... Y N
   B. Rheumatic fever or Rheumatic heart disease? .... Y N
   C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, High blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? .... Y N
   D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB Shortness of breath, severe cough)? .... Y N
   E. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?.. Y N
   F. Blood Disease (bleeding disorder, anemia, blood transfusion, bruise easily)?.. Y N
   G. Liver Disease (jaundice, hepatitis)? .... Y N
   H. Kidney Disease? .... Y N
   I. Diabetes?.. Y N
   J. Thyroid Disease (hypothyroidism, tumor)?.. Y N
   K. Arthritis (which joints)?.. Y N
   L. Stomach ulcers or intestinal problems?.. Y N
   M. Glaucoma?.. Y N
   N. Frequent or recurring mouth sores? .... Y N
   O. Implants/artificial joints anywhere in your body? (heart valve, hip, knee)?.. Y N
   P. Radiation (X-Ray treatment for cancer? In head and neck region)?.. Y N
   Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth?.. Y N
   R. Sinus or nasal problems?.. Y N
   S. Any disease, drug or transplant operation that has depressed your immune system?.. Y N
9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING
   A. Antibiotics?.. Y N
   B. Anticoagulants (blood thinners)? .... Y N
   C. Thyroid Medications?.. Y N
   D. Antihistamines, decongestants?.. Y N
   E. High blood pressure medications? .... Y N
   F. Steroids? .... Y N
   G. Tranquilizers, Antidepressants?.. Y N
   H. Stomach or GI medication (antacids, etc.)?.. Y N
   I. Cholesterol reducing drugs?.. Y N
   J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers?.... Y N
   K. Weight reduction pills or diet aids (over the counter or "natural" products)?.. Y N
   L. Vitamins, Natural remedies (ginkgo biloba, ephedra, ginseng, etc.) or other supplements?.. Y N
   M. Marijuana, cocaine or other "recreational" drugs?.. Y N
   N. Any other regular medication, pills, supplements or drugs?.. Y N

→→PLEASE LIST ALL CURRENT MEDICATIONS HERE____

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10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:
    A. Local anesthetic (Novocain-like drugs)? .... Y N
    B. Penicillin, Amoxicillin, Cephalosporin? .... Y N
    C. Other antibiotics? .... Y N
    D. Barbiturates, sedatives? .... Y N
    E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? .... Y N
    F. Codeine or other narcotics or opioids? .... Y N
    G. Latex? .... Y N
    H. Other allergies or reactions? .... Y N
    Please list: ______________________________

    ____
11. Do you have hay fever, frequent skin rashes, etc.? .... Y N
12. Do you use alcohol? How much per day? ______________________________ Y N
13. Do you smoke? .... Y N
    What product and how many per day? ______________ For how long? ______________
14. Do you use spit tobacco? .... For how long? ______________ Y N
15. Are you, or have you been, in a drug or alcohol recovery program? .... Y N
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
17. Do you wish to talk to the doctor privately about anything? .... Y N
18. Any additional comments? ______________________________

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19. **WOMEN**
    A. Are you taking birth control pills? .... Y N
    B. Are you pregnant, trying to become pregnant or any chance you might be pregnant:? .... Y N
    C. Are you **BREAST FEEDING**? .... Y N
    D. Are you taking hormonal replacement? .... Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

______________ ______________________________ [ ]

Date | Signature of person completing Health History | Doctor's Initials

THANK YOU. Please return this form to the receptionist before completing others in this packet; do not write below this line.

Medical Update: I have reviewed my health history dated ___/___/____and confirm that it accurately states past and present conditions.

Exceptions:

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______________ ______________________________ [ ]

Date | Signature of person completing Health Update | Doctor's Initials

Patient Information Form

Name ________________________________S.S.N. ____________________Date of Birth___________
Home Address __________________________________ City _____________ State______ Zip _______
Mailing Address _________________________________ City _____________State ______ Zip _______
Home Phone _____________ Cell Phone _____________ Email Address __________________________
How would you like for us to contact you: Text, Mail, Phone, Email
Place of Employment __________________________________ Work Phone ______________________
Address ______________________________________ City ______________State _______ Zip_______
Name of Spouse _______________________________________ Spouse Date of Birth ______________
Place of Employment ___________________________________ Work Phone _____________________
Whom may we contact in case of emergency ____
Relationship to you _______________________________ Home Phone _________________________
Work Phone _____________________________________ Cell Phone ____________________________
Nearest relative not living with you _______________________________Phone ___________________
Nearest friend not living with you _________________________________Phone ___________________
Physician ____ Phone ___________________
Last Dentist ____ Phone ___________________
How did you hear about our office? ____ Friend ____Website _____ Post card ____ Internet ____ Other
Name of Friend _______________________________

Responsible Party

Who is responsible for this bill ____
Relationship to patient ___________________________________ Home Phone ___________________
Address ____ Cell Phone ____________________
Driver's License Number _____________________________ State _______ Date of Birth ____________
Financial Institution ____________________________________ S.S.N.__________________________
Name of Employer ______________________________________ Phone __________________________
Employer Address ____
Is this person currently a patient in our office? ___________ Yes ___________ No
I will be paying today by: ___________ Cash ___________ Check ____________ Credit Card

Insurance Information

Name of Insured ____ Home Phone ___________________
Date of Birth _____________________ S.S.N. _____________________ Date Employed ____________
Name of Employer ____
Address of Employer _____________________________________ Work Phone ___________________
Insurance Company ______________________________________ Group Number ________________
Insurance Address ____Policy ID Number _______________

I understand and agree that payment for service is due at the time of treatment. I agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any services rendered by Dr. James Holman. If I have insurance, the percentage of the bill not covered by insurance is due at the time of service. I understand that there will a 1 ½ % service charge per month (18% APR) add to my overdue *accounts, and that I am responsible for all legal fees and collection fees. (*accounts are considered overdue 30 days past due) I have read all the information on both sides of this sheet and have completed all the answers. I certify that information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature ____ Date _________________________________
If patient is a minor, please have parent sign.

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, ____ have received a copy of
(Name of Patient)

Dr. James A. Holman Jr., D.D.S. 's notice of Privacy Acts.

(Signature of Patient)

(Date)

For office use only

Our office made good faith effort to obtain
Acknowledgement of receipt
Of our Notice of Privacy Practices,
But it could not be obtained for the following reason;

_______ Patient refused to sign

_______ Emergency situation kept us from obtaining the patient's signature

_______ Language barrier kept us from obtaining the patient's signature

Signed ____

Date ____

Notice of Privacy Practices
Dr. James A. Holman Jr., D.D.S.
3001 W. Illinois, Ste. 6A
Midland, TX 79701

This notice describes how health information about you may be used and disclosed and how you can get access to this information. If you have any questions about this notice, please contact our Privacy Officer.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Disclosure Your Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices when we give you our Notice of Privacy Practices. Once you have received our Notice, we will use your health information for treatment, payment, and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are the examples of the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentist and physicians to provide, coordinate or manage your health care. For example, your protected health care information may be provided to another specialist to whom you have been referred to ensure the necessary information is available to diagnose you.

Payment: Your protected health care information will be used to obtain payment for services we provide you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services recommended.

Healthcare Operations: We may also use your protected health care information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health care information to contact you and remind you of your appointment. We may send you information about treatment alternatives or products and services that may be of interest to you. We may also use your name to send you a newsletter about our practices and the services that we offer. You may contact the Privacy Officer to request that these materials not be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for our practices. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect your protected health information.

Your Written Authorization Is Required For Other Uses of Your Protect Health Information

Other uses of and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our practice has already release your information provided by your authorization.

How We Will Use Your Health Information with Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have opportunity to agree or object to the use or disclosure of the protected health information, and then we may use professional judgment and common practice to determent whether the disclosure is in your best interest. In this case, only the protected health information that is needed to provide your health care will be disclosed.

Family Member and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment and common practice to make reasonable decision in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions, or other forms of health circumstances.

Other Disclosures That May Be Made without Your Consent

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

Emergencies: We may use or disclose your protected 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 and safety or the health and safety of others.

Military Personnel and National Security: We may disclose the health information of Armed Force personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining your compliance.

You Have the Following Rights

Inspect and Copy Your Protected Health Information: You have the right to look at or get copies of your health information with limited expectations. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending us a letter using the contact information listed at the end of this notice. We will charge you a reasonable cost base fee for expenses. If you prefer, we will prepare a summary of an explanation of your health care information for a fee.

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

Request Additional Communications: 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 the request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you requested.

Request and Amendment of Your Health Information: You have the right to request that we amend or correct your health information. Your request must explain why the information should be amended or corrected. We may deny your request under certain circumstances.

Request an Accounting of Disclosures We Have Made Of Your Health Information: You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee.

Make A Fair Complaint About Our Privacy Practices: If you are concerned that we have violated your privacy rights, you file a complaint with the Department Of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or change the way we treat you.

Effective Date: April 14, 2003

Privacy Officer: Dr. James A. Holman Jr., D.D.S.
3001 W. Illinois Ave. Ste. 6A
Midland, TX 79701
(432) 682-6842

James A. Holman Jr., D.D.S.
Dental Treatment Consent Form

1. CONSENT FOR TREATMENT__________
   I give consent to James A. Holman JR., D.D.S. to perform dental treatment.

2. DRUG AND MEDICATIONS __________
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN _____________
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. REMOVAL OF TEETH___________
   Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissues (Paresthesia) that can last for a indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

5. CROWNS, BRIDGES AND CAPS ___________
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, size, fit and color) will be before cementation.

6. DENTURES, COMPLETE OR PARTIAL ___________
   I understand that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color)

will be “the teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after the initial placements. The cost for this procedure in not included in the initial denture fee.

7. ENDODONTIC TREATMENT (ROOT CANAL)___________
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and occasionally metal objects are cemented in the tooth, which does not necessary affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

8. PERIODONTAL LOSS (TISSUE & BONE) __________
   I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternatives treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by any one regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Date: _______________________________________

____
Signature of Patient or Parent/Guardian (if patient is under 18)

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from insurance companies with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. **Completing insurance forms is a courtesy we extent to you in an effort to save you time and to facilitate payment to our office from your insurance company.** Having our office process your insurance forms, does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated co-payment (the co-payment is the amount not covers by your insurance company) at the time we provide service to you. We will do our best to provide an accurate estimate of your portion of our fee, but there is no way for us to know the exact amount your insurance carrier will pay. If your carrier pays less than our estimate, you will be liable for the difference. If your carrier pays more than our estimate, and your account shows a credit balance, we will cheerfully issue to you a refund.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures. However, if your insurance claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company request to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and request of your insurance company. It is intimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and accept terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to the Doctor.

Print Patient's Name:____

Patient: ____ Date: _____________________