



Welcome to Donlan and Sudholt Dental

Thank you for choosing our office for all of your dental needs. We are committed to providing you with professional and personal dental care. At Donlan and Sudholt Dental, it is our goal to make each visit a comfortable and pleasant experience.

What to expect:

At your first visit, you will receive a thorough cleaning based on your needs assessed by the dentist and hygienist, x-rays, and a comprehensive exam completed by the dentist. It is our policy to take a full mouth set of x-rays at your first visit. Please check with your previous dentist as to whether you have a current full set of x-rays that can be forwarded to us. Most insurance companies have a five year limitation on full set of x-rays.

If dental restorations are needed outside of routine care, you will receive a treatment plan with an estimate of the costs for services needed. We will pre-estimate work needed upon request. The fees are valid for one year.

As a courtesy to you, we will file your insurance claims for services rendered in our office. Please note, we do not work directly with any insurance companies, therefore we are out of network and not a PPO provider.

Please note:

- Deductibles are due at the time of service. This fee varies amongst insurance companies
- An additional 20-50% of charges will be collected for dental work at the time of service if you have dental insurance on your account
- If no dental insurance is on your account, charges will be collected in full at the time of service

Also, every dental plan has provisions and limitations. Your dental benefits can be affected by:

- Yearly deductibles
- Yearly dental benefit maximums
- Waiting periods
- Replacement limitations on crowns, bridges, dentures, etc.
- Work done previously at another office (i.e. oral surgeons offices, endodontist offices)
- Missing tooth clause
- Limitations on full mouth, panorex, and bite wing x-rays

We look forward to working with you!

Sincerely,

Dr. John Donlan, D.D.S.

Dr. Nicole Sudholt, D.M.D.

DONLAN SUDHOLT DENTAL

Patient Information

Name: _____ Preferred Name : _____ DOB: __/__/__

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred way to be contacted: _____

Child/Student Single Married Widowed SSN: _____

Occupation: _____ Employer: _____ Work Phone: _____

Person responsible for account (Parent/Spouse/Self): _____

Other family members seen by us: _____

Emergency Contact: _____ Phone: _____

Y N Dental Insurance: (If Y, please present card to front desk for a copy. Thank you.)

Whom may we thank for referring you? _____

Dental History

Why have you come to the dentist today? _____

Y N Are you currently in pain? If Y please explain: _____

Y N Do you have TMD, clicking or popping of your jaw?

Y N Have you experienced problems with previous dental work? If Y please explain: _____

Y N Do you have periodontal disease?

Y N Do you experience dry mouth?

Y N Do you have sensitivity in your teeth or gums?

Y N Do you grind or clench your teeth?

Previous dentist: _____ Last visit date: _____

Why did you leave your previous dentist? _____

Y N Are you happy with the way your smile looks?

If not, what would you change? _____

Medical History (Confidential)

Physicians Name: _____ Date of last visit: _____

Do you have any known allergies? _____

Please list medications, vitamins or herbal remedies: _____

Please list any medical condition(s) that you have experienced: _____

Y N Do you require pre-medication prior to dental visits? Please explain: _____

Do you have any of the following? (Please circle Y or N)

- | | |
|--------------------------------------|-------------------------------|
| Y N Acid Reflux | Y N Headaches/Migraines |
| Y N Alcohol/Drug abuse | Y N Heart Attack: Date: _____ |
| Y N Alzheimer's Disease or Dementia? | Y N Hemophilia |
| Y N Angina: | Y N Hepatitis: Type: A? B? C? |
| Y N Artificial Heart Valve | Y N HIV+/AIDS |
| Y N Artificial Joints | Y N High Blood Pressure |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood disorders | Y N Osteoporosis |
| Y N Cancer | Y N Pacemaker |
| Y N Chemotherapy/Radiation Therapy | Y N Psychiatric Problems |
| Y N Cold sores/Fever Blisters: | Y N Sickle Cell Disease |
| Y N Congenital Heart Defect: | Y N Sleep Apnea |
| Y N Diabetes | Y N Smoke or use tobacco |
| Y N Epilepsy/Seizures | Y N Stroke |

If Y to any of the above, please explain:

Do you have any disease or medical problems not listed above? _____

For Women: Are you taking birth control pills? Y N Are you pregnant? Y N Nursing? Y N

To the best of my knowledge, the questions on this form have been accurately answered. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____ Date: _____

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 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 notice while it is in effect. This notice takes effect __/__/__ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of 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 notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practice, 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 disclose 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 for 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 operations, 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 sections 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 your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal 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 disclose of your health information, we will provide you with an opportunity to object to 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 persons 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 use 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 official's health information required for lawful intelligence, counterintelligence, and other national security

activities. We may disclose to correctional institution or law enforcement officials 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 look 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 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, we will charge you \$0. ___ for each page, \$___ per hour for staff time to locate and copy your health information., and postage if you want copies mailed to you. 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-monnth 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 means or location, and provide satisfactory explanation how payments will be handled under the alternative means 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 website 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 means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complain to the US Department of Health and Human Services. We will provide you with the address to file your complaint with US 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 US Department of Health and Human Services.

Contact Officer: _____

Telephone: 309-691-9421

Fax 309-691-1390

Email: donlansudholdental@gmail.com

Address: 843 West Glen Ave Peoria IL 61614

Payment Agreement and Acknowledgement of Receipt of Notice of Privacy Practices

- Patients with dental insurance:

Routine visits are generally covered by insurance, please be advised we do not work directly with any insurance companies. If for any reason your insurance company does not pay the full amount, you will be responsible for the entire account balance. A standard deductible of \$50 will be collected, along with 20% or 50% of the total cost of services completed, excluding routine cleanings and exams. Any payment not received within 60 days will be subject to an interest fee of 1.75 % per month (21% APR).

- Patients without dental insurance:

We are a fee for service office. Therefore, patients without dental insurance will be required to pay for dental services in full at each appointment.

I (patient) am liable for all costs of collection, including collection agency fees (not to exceed 33.3%), all reasonable attorney's fees and court costs.

I hereby authorize the treating dentist to release any information relating to my claims with this office. I understand that I am responsible for all costs of dental treatment incurred by myself or my family. I hereby authorize payment of the dental benefits otherwise payable to me, directly to Donlan Sudholt Dental. A copy of this authorization is valid for claims and can be faxed.

**** I am also acknowledging that I have received a copy of this office's Notice of Privacy Practices****

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name

Signature of patient or guardian

Date