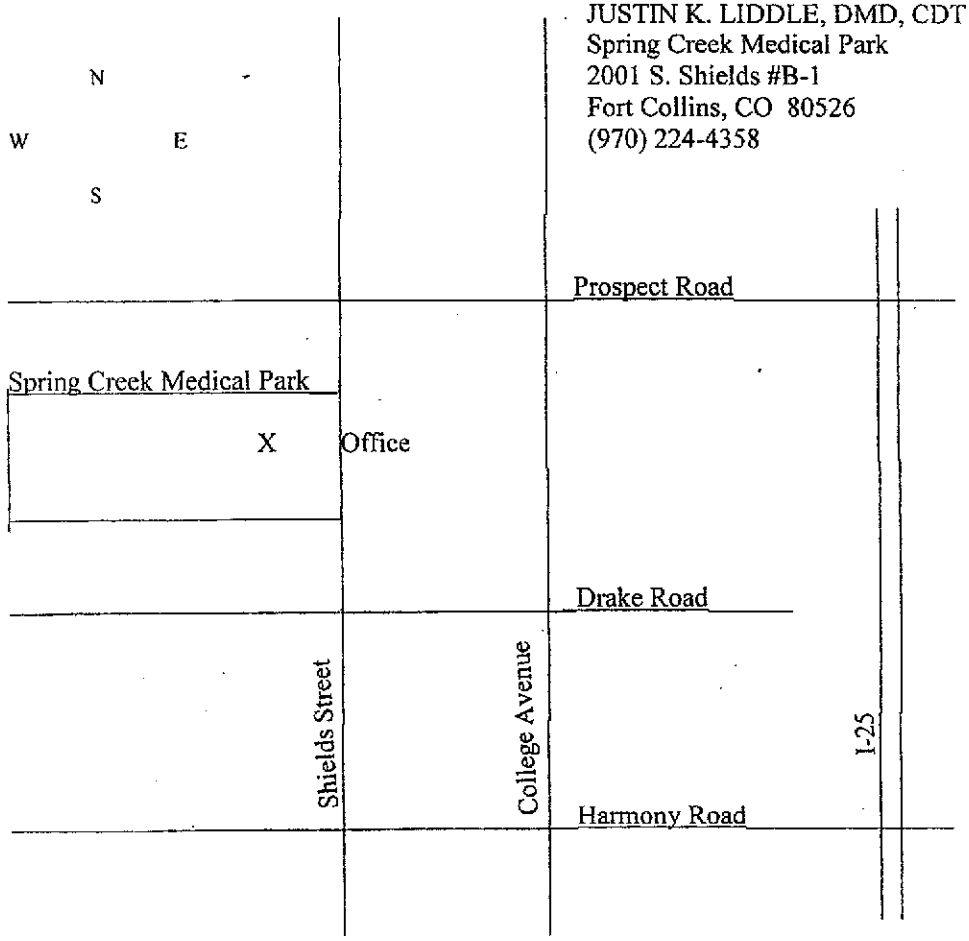
JUSTIN K. LIDDLE, DMD, CDT
Spring Creek Medical Park
2001 S. Shields #B-1
Fort Collins, CO 80526
(970) 224-4358



JUSTIN K. LIDDLE, D.M.D., L.L.C.
2001 S. Shields, Building B-1 (970) 224-4358 Fort Collins, CO 80526

PROSTHODONTIC PATIENT INFORMATION

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your prosthodontic problem during your initial examination in our office. In order for Dr. Liddle to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential.

PATIENTS NAME _____
First Middle Last

IF CHILD UNDER LEGAL AGE, NAME OF GUARDIAN _____

PATIENTS DATE OF BIRTH _____ SOCIAL SECURITY # _____ HOME # _____

HOME ADDRESS _____ WORK # _____

CITY AND STATE _____ ZIP CODE _____

PATIENTS OR GUARDIAN'S EMPLOYER _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

PERSON WE MAY CONTACT IF PATIENT CANNOT BE REACHED:

_____
Name Phone number Relationship

IS PATIENT COVERED BY INSURANCE THAT COVERS PROSTHODONTIC TREATMENT? Yes No

NAME OF INSURANCE COMPANY _____

ADDRESS OF INSURANCE COMPANY _____ CITY _____ STATE ____ ZIP _____

INSUREDS' EMPLOYER _____ EMPLOYEE S.S.# _____ BIRTH DATE _____ GROUP # ____

EMPLOYEE'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

We are happy to file your insurance as a courtesy to you, however, payment is required at the time services are rendered.

I have read and fully understand the above information and authorize the release of any information for the purposes of payment of insurance benefits.

NAME DATE

_____

PATIENT INFORMATION SHEET

HEIGHT_____ WEIGHT_____

DO YOU HAVE OR HAVE YOU HAD:

HEART TROUBLE	YES NO	ARTHRITIS	YES NO
RHEUMATIC FEVER	YES NO	PROSTHETIC JOINT (i.e. hip)	YES NO
HEART MURMUR	YES NO	RESPIRATORY DISEASE	YES NO
HEART VALVE REPLACEMENT	YES NO	LUNG DISEASE	YES NO
ALLERGIES	YES NO	ABNORMAL BLEEDING	YES NO
ABNORMAL BLOOD PRESSURE	YES NO	MALIGNANCIES (CANCER)	YES NO
ANEMIA	YES NO	RADIATION TREATMENT	YES NO
DIABETES (SUGAR)	YES NO	PREVIOUS OPERATIONS	YES NO
EPILEPSY	YES NO	VENEREAL DISEASE	YES NO
LIVER DISEASE	YES NO	CONVULSIONS OR SEIZURES	YES NO
HEPATITIS OR JAUNDICE	YES NO	DO YOU HAVE A COLD	YES NO
STROKE	YES NO	MIGHT YOU BE PREGNANT	YES NO
ULCER DISEASE	YES NO	KIDNEY TROUBLE	YES NO

TO THE BEST OF YOUR KNOWLEDGE, IS THERE A POSSIBILITY THAT YOU HAVE BEEN EXPOSED TO THE AIDS (ACQUIRED IMMUNE DISORDER) VIRUS YES NO

HAVE YOU BEEN HOSPITALIZED IN THE PAST FIVE YEARS?_____

DATE OF YOUR LAST PHYSICAL EXAM _____

NAME OF YOUR FAMILY DENTIST _____

NAME OF YOUR FAMILY PHYSICIAN _____

LIST ANY SERIOUS OPERATIONS _____

HAVE YOU EVER TAKEN ANY CORTISONE OR OTHER STEROIDS? _____

LIST ANY MEDICATIONS YOU ARE TAKING _____

_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO _____

_____

DO YOU TAKE ANTICOAGULANTS (BLOOD THINNING DRUGS)? _____

DO YOU SMOKE? _____

DO YOU HAVE ANY OTHER DISEASE OR CONDITION NOT LISTED? _____

_____

_____

SIGNATURE DATE

CONFIDENTIAL HEALTH HISTORY

JUSTIN K. LIDDLE, D.M.D., L.L.C.
Spring Creek Medical Park
2001 S. Shields, Bldg. B-1
Fort Collins, CO 80526

OFFICE PAYMENT POLICY

1. **Payment for services is expected when services are rendered.**

2. Treatment Plans that require multiple visits require one-half the total charge to be paid at the time the overall Treatment Plan begins. Balance to be paid upon completion of treatment.

3. Our office is happy to file your Dental insurance and any additional information in order for you to receive payment by your insurance carrier. However, due to the extremely slow turn around by insurance carriers, our office no longer accepts assignment, (which means that payment by your insurance carrier should be mailed directly to you, if we receive the payment and you have a balance with our office it will be applied to your account, if you have a zero balance with our office we will forward the check to you). Our office also does not participate in any HMO or PPO insurance programs. Payment by your insurance carrier is not based on our actual charges for the procedure it is based on a fee pre-established by your insurance carrier. The total charge by our office is the responsibility of the patient.

4. A $25 Late Payment Fee will be charged to all accounts over 60 days each billing cycle, until the balance is paid in full.

5. We require 24 hours notice for cancellation of appointments. After two NO-SHOW appointments there will be a charge of $25 per hour of scheduled time will be applied.

_____ _____

Signature *Date*

We accept Visa, MasterCard, Discover and American Express.

JUSTIN K. LIDDLE, D.M.D., L.L.C. NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The Law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of our health information to another practice. We will mail your files for you with a signed release.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 970-224-4358.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of Justin K. Liddle, D.M.D., L.L.C. Notice of Privacy Practices.

_____ _____ _____

Signature Date Print Name

If signing as a parent or guardian, please note the name of the patient_____.