

Dr. Benjamin T. Watson III, DDS  
A Division of Atlantic Dental Care, Plc.

Notice of "Deemed Consent" To HIV and Hepatitis B and C Testing and Release of Test Results in  
Exposure Accidents

Even though needle stick or puncture wounds are uncommon in the dental office, as a health care provider we are required by Statute 32.1-45.1 code of Virginia (1950) as amended (1990) and (1993) to give you the following notice:

If Dr. Watson or a staff member of his office should be directly exposed to your blood in a way that may, according to current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses. Test results will be released to the person who was exposed.

If you should be directly exposed to blood or bodily fluids of Dr. Watson or a staff member of his office in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus and hepatitis b and c viruses. A healthcare provider will tell you and that person the results of the tests.

Prescription Monitoring Program

In response to serious public health concerns related to prescription drug abuse in Virginia, the General Assembly has passed legislation establishing a statewide Prescription Monitoring Program. This program collects prescription data for specified drug schedules into a central database, which can then be used by authorized users to promote the appropriate prescribing and dispensing of controlled substances for legitimate medical purposes while deterring the illegitimate use of these drugs.

I, as a patient of Dr. Benjamin T. Watson, realized that Dr. Watson will clear thru the Prescription Monitoring Program any Schedule II-V drugs prior to prescribing.

This is to certify that I have been informed of the above information.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Dr. Benjamin T. Watson III, DDS  
A Division of Atlantic Dental Care, PLC.

Financial Agreement/Release of Information of Benefits

It is the policy of Dr. Benjamin T. Watson, III to file insurance claims as a courtesy to the patient. The financial responsibility for services rendered rests solely with the patient/guarantor. The agreement of the insurance company to pay for medical and dental care is a contract between the patient and the insurance company. It is the patient/guarantor's responsibility to pay at the time of service for any non-covered service, deductibe, co-payments, or any other balance not paid by the insurance company.

The patient appointment times have been exclusively reserved. We therefore require at least 24 hours advance notice if the patient is going to cancel his or her appointment. Failure to cancel 24 hours in advance or failure to show up for a scheduled appointment could result in a \$40.00 charge.

I hereby authorize treatment by Dr. Watson. I also authorize release of records to any agency involved in the payment of treatment of the patient mentioned below. I assign all benefits to Dr. Watson and understand that in the event that collection action is necessary I am responsible for all collection-related fees, including a 33% attorney fee at the time my account is referred to an attorney. I am responsible for a \$25 fee for a personal check returned to Dr. Watson for any reason.

Patient Name (please print): \_\_\_\_\_

Patient/Guarantor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL INFORMATION

Name and address of physician: \_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS THAT YOU TAKE BELOW

Name of Drug: \_\_\_\_\_ For What Purpose: \_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any bisphosphonates or blood thinners (including baby aspirin)? Yes \_\_\_ No \_\_\_

Are you allergic to any of the following (please circle): Penicillin Sulfa Codeine Local Anesthetics  
Tetracycline Aspirin Latex

Are you allergic to any other medications? Yes \_\_\_ No \_\_\_

If so, please list additional allergies here: \_\_\_\_\_

HAVE YOU BEEN TREATED OR TESTED POSITIVE FOR ANY OF THE FOLLOWING:

Heart Condition Yes \_\_\_ No \_\_\_ HIV/Aids Yes \_\_\_ No \_\_\_

Rheumatic Fever Yes \_\_\_ No \_\_\_ Hepatitis Yes \_\_\_ No \_\_\_

Abnormal Blood Pressure Yes \_\_\_ No \_\_\_ Jaundice Yes \_\_\_ No \_\_\_

Anemia Yes \_\_\_ No \_\_\_ STI (Syphilis, Herpes, Etc.) Yes \_\_\_ No \_\_\_

Cancer Yes \_\_\_ No \_\_\_ Tuberculosis Yes \_\_\_ No \_\_\_

If so, what type? \_\_\_\_\_ Asthma or Hay Fever Yes \_\_\_ No \_\_\_

\_\_\_\_\_ Arthritis Yes \_\_\_ No \_\_\_

Joint Replacement Yes \_\_\_ No \_\_\_ Osteoporosis Yes \_\_\_ No \_\_\_

Diabetes Yes \_\_\_ No \_\_\_ Stroke Yes \_\_\_ No \_\_\_

If so, is it Type I or Type II? \_\_\_\_\_ Glaucoma Yes \_\_\_ No \_\_\_

Epilepsy Yes \_\_\_ No \_\_\_ Serious Accident Yes \_\_\_ No \_\_\_

Ulcers Yes \_\_\_ No \_\_\_ Fainting Spells Yes \_\_\_ No \_\_\_

Prolonged Bleeding Yes \_\_\_ No \_\_\_ Sleep Apnea Yes \_\_\_ No \_\_\_

If so, do you use a CPAP? Yes \_\_\_ No \_\_\_

Does your physician recommend that you take pre-medication? Yes \_\_\_ No \_\_\_

Are you currently pregnant? Yes \_\_\_ No \_\_\_ Are you or have you used recreational drugs? Yes \_\_\_ No \_\_\_

Is there any other information about your medical history that you feel we should know? \_\_\_\_\_  
\_\_\_\_\_

## DENTAL INFORMATION

Name and address of last dentist: \_\_\_\_\_  
\_\_\_\_\_

Are you pleased with the appearance of your teeth? Yes \_\_\_ No \_\_\_

In the last 3 years have you had: Bitewing (cavity detecting) x-rays? Yes \_\_\_ No \_\_\_

Full-mouth series (all teeth)? Yes \_\_\_ No \_\_\_

Panoramic x-ray (one large film)? Yes \_\_\_ No \_\_\_

DO YOU HAVE OR HAVE YOU HAD:

Full dentures Yes \_\_\_ No \_\_\_ Pain in your jaw or face Yes \_\_\_ No \_\_\_

Partial dentures Yes \_\_\_ No \_\_\_ A clicking jaw joint Yes \_\_\_ No \_\_\_

Orthodontic treatment Yes \_\_\_ No \_\_\_ Difficulty opening your mouth Yes \_\_\_ No \_\_\_

Gum treatment/surgery Yes \_\_\_ No \_\_\_ Unpleasant odor/taste in your mouth Yes \_\_\_ No \_\_\_

TMJ (Jaw Joint) treatment Yes \_\_\_ No \_\_\_ Bleeding gums Yes \_\_\_ No \_\_\_

Sensitive teeth Yes \_\_\_ No \_\_\_ Clenching or grinding teeth day or night Yes \_\_\_ No \_\_\_

If so, is it sensitivity to hot, cold, or pressure? Food catch between your teeth Yes \_\_\_ No \_\_\_

Is there any other dental information that we need to know? \_\_\_\_\_  
\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT REGISTRATION AND HEALTH HISTORY**

Patient's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Nickname \_\_\_\_\_ Are you married/single/widowed/divorced? \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email Address \_\_\_\_\_ Social Security Number \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_  
Purpose of this visit \_\_\_\_\_  
If patient is a minor, please give parent or guardian's name \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

**PRIMARY INSURANCE**

Subscriber's Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Subscriber's Social Security Number \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Is this insurance through an employer? Yes \_\_\_ No \_\_\_ Employer \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_  
Subscriber Identification Number \_\_\_\_\_  
Dental Insurance Company Address \_\_\_\_\_  
\_\_\_\_\_

**SECONDARY INSURANCE**

Subscriber's Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Subscriber's Social Security Number \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Is this insurance through an employer? Yes \_\_\_ No \_\_\_ Employer \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_  
Subscriber Identification Number \_\_\_\_\_  
Dental Insurance Company Address \_\_\_\_\_  
\_\_\_\_\_

**OFFICE POLICY**

As a courtesy to our patients we are happy to bill the patient's insurance company. However, individuals who subscribe to an insurance plan fully understand that all dental services are charged directly to the patient and that he or she is ultimately responsible for any and all such services not totally covered by the insurance policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Benjamin T. Watson, III, DDS, MAGD  
A Division of Atlantic Dental Care, PLC

**AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION**

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other names under which the Patient has been treated: \_\_\_\_\_

I authorize Dr. B. T. Watson, III and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below:

- Relevant Time Period.** Dr. Watson may use or disclose information relating to healthcare provided during the following time period:  
 Anytime.  
 Healthcare provided between (date) \_\_\_\_\_ and (date) \_\_\_\_\_.
- Types of Information.** Dr. Watson may use or disclose the following type(s) of information:  
 Any information concerning the Patient's healthcare or payment during the relevant time period.  
 Medical records concerning the Patient's healthcare during the relevant time period, including:  
 Records from the Patient's chart (e.g., history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.)  
 Diagnostic images, films or other recordings (e.g., x-rays, perio charting, or intral-oral photos.)  
 Billing and payment records for healthcare rendered during the relevant time period.  
 Other: \_\_\_\_\_
- Persons to Whom Disclosure Allowed.** Dr. Watson may disclose the information to the following entity(ies):  
Name or description: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_
- Purpose.** Dr. B. T. Watson may use or disclose the information for the following purpose(s):  
 The disclosure is made at the Patient's request.  
 For a potential or pending legal proceeding.  
 For the purpose of a referral to an outside specialist such as an orthodontist, oral surgeon, etc.  
 Other: \_\_\_\_\_

I understand that I have the right to revoke this authorization at anytime except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

**Contact person: Donna Dinquel, Financial Coordinator**

I understand that Dr. B. T. Watson may not condition the Patient's healthcare on this authorization unless (1) the purpose for Dr. Watson's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Dr. Watson pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: \_\_\_\_\_  
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authority or relationship to the Patient  
\* Give a copy of the authorization to the Patient or personal representative.