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.

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

Name (please print): ____

Signature: ____

Dr. Benjamin T. Watson III, DDS
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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: ____

BENJAMIN T. WATSON III, DDS A Division of Atlantic Dental Care, Plc.

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 ___________________________________

AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION

Patient: ______________________________ Date of Birth: ______________
Address: ______________________________
____
Telephone: ______________________________

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.

1. **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*) ______________.
2. **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: ______________________________
3. **Persons to Whom Disclosure Allowed.** Dr. Watson may disclose the information to the following entity(ies):
   Name or description: ______________________________
   Address: ______________________________
   ____
   Phone number: ______________________________
4. **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.
   - ☐ 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: Dr. Benjamin T. Watson, III

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.*

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