

BENJAMIN T. WATSON III, D.D.S.

PATIENT REGISTRATION AND HEALTH HISTORY

Patient's Full Name _____ Date of Birth _____ Single
Nickname _____ Name of Spouse _____ Married
Address _____ Separated
_____ Divorced
Home Phone _____ Work Phone _____ Widowed
Social Security # _____
Referred by _____
In case of emergency, who should we contact? _____
Purpose of this visit? _____
If patient is a minor, give parent or guardian's name _____

Person financially responsible _____

PRIMARY INSURANCE

Insured's Name _____
Address _____

Home Phone _____ Work Phone _____
Social Security # _____
Date of Birth _____ Relation to Patient _____
Employer _____
Address _____

Dental Insurance Co. _____ Policy # _____

SECONDARY INSURANCE

Insured's Name _____
Address _____

Home Phone _____ Work Phone _____
Social Security # _____
Date of Birth _____ Relation to Patient _____
Employer _____
Address _____

Dental Insurance Co. _____ Policy # _____

OFFICE POLICY

As a courtesy to our patients we are happy to bill insurance. 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 _____

MEDICAL INFORMATION

Name and Address of Physician _____

Date of last physical _____

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

Name of drug	For what purpose
_____	_____
_____	_____

ARE YOU ALLERGIC TO

Penicillin	Sulfa	Others:
Codeine	"Novacaine"	
Tetracycline	Aspirin	

ANY OTHER MEDICATIONS?

HAVE YOU EVER BEEN TREATED FOR OR TESTED POSITIVE FOR:

Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV (AIDS)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Valve Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	VD (Syphilis, Gonorrhea, Herpes, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital Heart Lesions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma or Hay Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia (Blood Transfusions)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer (what type?)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prosthetic Joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Serious Accident	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sudden Weight Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fainting Spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Prolonged Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Night Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you had any blood transfusions in the past 5 years? 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? _____

What fears do you have about your dental visits? _____

In the last 3 years have you had:

Bitewing (cavity-detecting) x-rays	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Full-mouth series (all teeth)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Panorex x-ray (one large film)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

DO YOU HAVE OR HAVE YOU HAD:

Full Dentures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Partial Dentures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How old are they?		
Orthodontic treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gum treatment/surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
TMJ (jaw joint) treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sensitive teeth		
Cold	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>

DO YOU HAVE OR HAVE YOU HAD:

Pain in your jaw joint or face	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A clicking jaw joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty opening your mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Unpleasant odor/taste in your mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding gums	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clenching or grinding teeth day or night	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Food catch between your teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Is there any other dental information you feel we need to know? _____

Patient's Signature _____ Date _____

Updates: _____

BENJAMIN T. WATSON, III
729 THIMBLE SHOALS BLVD., BUILDING 7E
NEWPORT NEWS, VA 23606
(757) 873-3322

NOTICE OF "DEEMED CONSENT"
TO HIV TESTING OR HEPATITIS B OR C VIRUSES
AND RELEASE OF TEST RESULTS IN
EXPOSURE INCIDENTS

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

If you should be directly exposed to blood or body fluids of Dr. Watson or 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, hepatitis B and C viruses. A health care 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 _____ Date _____



Dr. Benjamin F. Watson, III
General Dentistry

729 Thimble Shoals Blvd.
Building 7E
Newport News, VA 23606
873-3322

FINANCIAL AGREEMENT/RELEASE OF INFORMATION/ASSIGNMENT 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 care is a contract between the patient and the insurance company. It is the patient's/guarantor's responsibility to pay at the time of services for any non-covered service, deductible, co-payments or any other balance not paid by the insurance company.

The patient's appointment times have been exclusively reserved. We, therefore, require 24 hours' advance notice if the patient is going to cancel his/her appointment. Failure to cancel 24 hours in advance or failure to show up for a scheduled appointment could result in a \$30.00 charge which is not covered by insurance.

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 and a 33 $\frac{1}{3}$ % attorney fee at the time my account is referred to an attorney. I am responsible for a \$25.00 fee for a personal check returned to Dr. Watson for any reason.

Patient Name (Please Print) _____

Patient/Guarantor's Signature _____

Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Donna Dinquel

Telephone: 757.873.3322 Fax: 757.873.8407

E-mail: mcvur@aol.com

Address: 729 Thimble Shoals Blvd. 7E, Newport News, VA 23606

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.