Welcome to our practice Please complete and sign

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_ (first) (middle initial) (last)

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_ (no P.O. Box)

Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Soc. Sec. Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person to notify in case of emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physicians Name and Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_ Who may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following conditions? (circle all that apply) Anemia Thyroid Trouble Scarlet Fever Asthma Rheumatic Fever Aids Virus/HIV Cancer Heart Murmur Severe Headaches Diabetes Mitral Valve Prolapse Arthritis or Rheumatism Epilepsy Heart Surgery Seizures or Convulsions Fainting Spells High Blood Pressure Radiation Treatment Hepatitis Bleeding Problems Chemotherapy Jaundice Hemophilia Recent Change of Weight Immune Deficiency Emphysema TMJ or TMD Pneumonia Frequent Sinus Infections Psychiatric Problems Transfusions Mononucleosis Drug Dependency Prosthetics: Hip, Knee, Joint Heart Valve Liver Disease Alcohol Dependency Tuberculosis Kidney Disease Problems with Local Anesthetic Glaucoma Lung Disease Problems with Dental Treatment Heart Attack Angina/Chest Pain Allergy to Latex Please list all medications and dosages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you taking blood thinners? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Coumadin/Aspirin)?\_\_\_\_\_\_ Please list all drug allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list medical conditions you are being treated for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you pregnant? \_\_\_\_\_\_\_ Which Trimester? \_\_\_\_\_\_\_\_\_\_\_\_ Do you use tobacco? \_\_\_\_\_\_\_ What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use alcohol?\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use recreational drugs?\_\_\_\_\_\_\_\_ Has your doctor recommended antibiotics prior to dental treatment? \_\_\_\_\_\_\_\_\_\_\_ Name and number of Orthopedic Surgeon if you have had a prosthesis placed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is responsible for the account balance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*We will file your insurance but you will be responsible for all payment not covered by insurance. Failure to pay in a timely fashion will result in additional collection and legal fees.

The above information is correct to the best of my knowledge. I give consent for dental treatment.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_ I give consent to allow dental treatment of my child (or a minor). Relation to child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Alexandra L. Wood, DDS & Douglas L. Starns, DDS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

 I hereby give my consent for Douglas L. Starns, DDS and Alexandra L. Wood, DDS (or personnel employed by same) to use and disclose protected health information (PHI) about me to carry out treatment, payment and oral healthcare operations (TPO).

I reserve the right to review the Notice of Privacy Practices prior to signing this consent. Douglas L. Starns and Alexandra L. Wood reserve the right to revise this Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Douglas L Starns DDS, 240 Hydraulic Ridge Road Suite 102 Charlottesville, Va 22901.

With this consent, Douglas L. Starns and Alexandra L. Wood (or personnel employed by same) may call my or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results.

With this consent, Douglas L. Starns and Alexandra L. Wood may mail to my home or other alternative location any items that assist the practice in carrying out (TPO), such as appointment reminder cards and patient statements.

I have the right to request that Douglas L. Starns and Alexandra L. Wood restrict how they use or disclose my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the practice’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Douglas L. Starns and Alexandra L. Wood may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name of Patient or Legal Guardian

 Starns and Wood Comprehensive Dentistry 240 Hydraulic Ridge Road, Suite 102 Charlottesville, VA 22901

 Financial Policy

It is our goal to provide you, your friends and family members with affordable, high-quality dental treatment. We feel it is important that you read and understand our financial policy. Should you have any questions, please do not hesitate to ask us about our payment options and/or insurance administration.

IF INSURED: If you come prepared with all pertinent dental insurance information we will gladly file your insurance claim(s) as a courtesy. Your insurance policy is a contract between you and your insurance company. As the patient/responsible party, you are responsible for knowing your insurance coverage, allowances, deductibles, yearly maximums, etc. Benefit plans vary from employer to employer and can be very confusing, thus it is always best to request a breakdown from your human resources person or directly from your insurance carrier. We will be happy to assist you with claims administration whenever possible but are not responsible for your insurance company’s final decision. Please keep in mind that the financially responsible party is accountable for any unpaid balance regardless of insurance coverage. Preauthorization of benefits will be submitted at your request.

IF UNINSURED: Payment, in full, is expected at the time services are rendered unless other financial arrangements have been made in advance. Your financial responsibility can be estimated prior to each of your appointments, at your request.

UNPAID BALANCES: All unpaid balances will be subject to additional collection/billing fees (including court costs and attorney fees).

I understand the above information and agree to its contents

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

 Screening for Sleep Apnea

1. Do you snore? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How often do you snore? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has anyone ever complained about your snoring? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you ever wake up during the night gasping for breath? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has anyone noticed that you stop breathing during your sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you sleepy during the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you feel the need to nap to make it through your day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever nodded off or fallen asleep while driving a vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you ever been diagnosed with Sleep Apnea? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Have you ever worn a CPAP (Continuous Positive Airway Pressure) device? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **WELCOME** to Starns and Wood, Comprehensive Dentistry

Welcome to our practice! We look forward to meeting with you. You will be seen for a complete evaluation, followed by a cleaning with our dental hygienist. The appointment takes 90 minutes and we will be on time for you. Please arrive 15 minutes early, with completed forms.

The medical history allows us to treat you safely. If you have been told by your physician to take an antibiotic prior to dental treatment, the medication should be taken 1 hour prior to your appointment. If you are out of your medication, please call our office, (434) 973-1392.

During your first visit, we will learn about your dental needs and concerns. These might include tooth or gum pain, or concerns about your smile. Digital Radiographs (extremely low-radiation x-rays) will be taken to help us with our diagnosis. An oral cancer screening, gum disease assessment, and complete evaluation of your teeth and bite will follow. A report will be sent to you the following day by mail or email that includes our findings, treatment options, recommendations, and fee estimate.

 We ask that you pay for your dental care as it progresses. We will file your insurance claim for you, but you will be responsible for any amount not covered by your insurance provider. Bring your insurance card to your appointment to allow us to process your claim.

If it becomes necessary to change your appointment time, 24 hours previous notice is required. This allows us to help other patients in need. There is a broken appointment fee ($35/hour).

Our office is located directly across the street from the main entrance to Albemarle High School. After rising up the steep driveway (Hydraulic Ridge Road), turn right to the 240 Hydraulic Professional Building and proceed to the middle office on the bottom level. An American flag is located in our parking lot. We have plenty of parking for your convenience. Warning: your GPS may not bring you to the correct area. Call (434) 973-1392 if you are lost.

We are happy you have chosen Starns and Wood to care for your dental needs. We provide the best care available and are deeply committed to the health and welfare of our patients. If you have further questions, please call our office manager, Sharon, (434) 973-1392.

Warmest regards,

Dr. Starns, Dr. Wood and Staff