Dr. William Moore
General Dentistry

WILLIAM U. MOORE, D.D.S., PLLC
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A copy of the Notice of Health Information Practices is posted for your review. Please sign below.

Date _____ Signed _____

I hereby authorize William Moore General Dentistry to release information to my insurance company. I hereby assign and direct payment to William Moore Dentistry of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. I understand I am financially responsible to the corporation for charges/charged amounts not covered by this agreement.

Date _____ Signed _____

Virginia State law provides that when a healthcare worker is exposed to the body fluids of another person in a manner which may transmit human immunodeficiency virus (HIV – the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to testing for HIV and to the release of the results to the exposed person and the local health department.

Date _____ Signed _____

By becoming a patient of William Moore Dentistry and presenting myself for appointments with the dentist or dental hygienist of William Moore Dentistry. I consent to and authorize treatment by the qualified care providers of William Moore Dentistry. Qualified care providers include, but are not limited to dentists, dental hygienists, dental assistants, etc. I hereby agree that the care providers may examine me, perform non-invasive diagnostic tests and treatment to be performed, and that I will sign a separate authorization for any invasive diagnostic tests or dental procedure to be performed.

Date _____ Signed _____