Bruce A. Woodruff, D.M.D.

www.tmjtallahassee.com

Welcome to the practice of Dr. Bruce Woodruff. Our practice is limited to diagnosing and non-surgically treating TMJ patients. Please allow us to provide a little information regarding your first visit.

Your appointment time and date: _____

- **Please allow 48 hours to change or cancel your appointments**
- **Please fill out the new patient forms prior to your first appointment**
- **Please be on time for your appointments. Dr. Woodruff typically does not run late.**
- **Due to the large number of patients seeking care in Dr. Woodruff's practice, we will call two days prior and ask for voice confirmation by 3 PM the day before your appointment. If not received, we will automatically cancel the appointment. Voice confirmation means speaking to one of our staff members on the phone or leaving a message on our answering machine.**
- **Please do not wear perfume or cologne to our office.**
- **Dr. Woodruff is a Capital Health Plan provider and all CHP patients only pay their Specialist copay for ALL services rendered. All other patients will be requested to pay all fees incurred at the time of the visit out-of-pocket and have any provided insurance payments refunded by our practice. We do provide to the patient all claims and supporting documentation to file with the insurance company.**

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ABOUT OUR PRACTICE:

- Dr. Woodruff is a Georgia Tech trained Electrical Engineer, received his Dental degree from the University of Florida and then completed a one year Fellowship/Residency at the UF Shands Facial Pain Center. Dr. Woodruff is one of only a few Dentists in Florida with this level of training.
- Our typical TMJ patient experiences some of the following:
    - Jaw pain
    - Jaw joint dysfunction in the form of popping and/or locking.
    - Headaches in the temples or back of head
    - Limited jaw opening
    - Ear pain or pressure
    - Sore teeth
    - Teeth grinding/clenching
- What to expect at your initial visit with Dr. Woodruff:
    - Panoramic Radiograph **(please let us know if you prefer to not undergo this x-ray)**
    - You will be asked for a history of your TMJ issues
    - Simple head, neck and oral examination
    - Diagnosis of your condition
    - Treatment suggestions
- Our typical treatments include:
    - Occlusal nightguards
    - Simple physical modalities
    - Injections (small percentage of patients)
    - Medication suggestions (small percentage of patients)
    - Dr. Woodruff does not prescribe narcotic pain medication
    - After numerous months of non-surgical treatment, a small percentage of our patients with unimproved jaw joint problems are referred to an Oral Surgeon for evaluation of possible TMJ surgical options.
- Dr. Woodruff also spends a small percentage of his practice time treating Obstructive Sleep Apnea patients who have previously undergone sleep studies. The oral appliance he provides can treat mild-to-moderate sleep apnea.

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT)

Patient _____ _____ _____ _____
Last Name First Name M.I. Preferred Name

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer/School _____ Occupation _____

Employer/School Address _____

Social Security# (Last Four)_____ Spouse/Parent Name _____

Medical Insurance Company _____ Who is responsible for this account? _____

In case of emergency, who should be notified? _____ Phone (____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Primary Care Physician's Name __ _____ Date of Last Physical _____

Have you ever had or have any of the following? (check boxes that apply):

☐ ADD/ADHD
☐ Allergic Rhinitis
☐ Anorexia / Bulimia
☐ Anxiety
☐ Arthritis: If yes, type: _____
☐ Artificial Heart Valves or Joints
☐ Asthma
☐ Back Problems
☐ Bi Polar Disorder
☐ Bleeding Abnormally
☐ Cancer: If yes, type: _____
☐ Chemical Dependency
☐ Circulatory Problems
☐ Congenital Heart Problems
☐ Depression
☐ Diabetes 1 or ☐ Diabetes 2
☐ Ear Pain
☐ Epilepsy
☐ Fibromyalgia
☐ GERD (Acid Reflux)
☐ Heart Murmur
☐ Heart Problems
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV / AIDS
☐ Hysterectomy
☐ Insomnia
☐ Liver or ☐ Kidney Problems
☐ Migraine or ☐ Tension Headaches
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation or Chemotherapy
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems (☐Occasional) (☐Chronic)
☐ Sleep Apnea
☐ Snoring
☐ Stroke
☐ Thyroid Disorder
☐ Ulcer
☐ Jaw Popping
☐ Teeth Clenching or Grinding

Are you taking any **Medications** at this time? ☐ **Yes** ☐ **No** **If Yes, please list**:

_____

_____

_____

Please briefly list any **Surgeries**:

_____

_____

Do you have any **Drug Allergies** or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If yes, please list: _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No If patient is a child, what is his/her weight? _____

(**Women**) Do you suspect that you are **Pregnant**? ☐ Yes ☐ No Due Date _____ Are you **Nursing**? ☐ Yes ☐ No

Is there anything else we should know about your medical history?

_____

INSURANCE ASSIGNMENT AND RELEASE

Capital Health Plan Members:

I certify that I (or my dependent below) am covered by medical insurance with Capital Health Plan and assign directly to Dr. Bruce Woodruff all insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all appropriate co-payments at the time of service. Occasionally, services provided by Dr. Woodruff are not covered by CHP such that payment is expected at time of service. Notification of non-covered services will be provided in advance by Dr. Woodruff. Patients are to disclose prior to services any knowledge that coverage may not be provided by CHP. Dr. Woodruff will disclose your (or your dependent's) information to CHP for the purpose of obtaining payment for services and determining insurance benefits. I authorize the use of my signature on all insurance submissions.

Non-Capital Health Plan Members:

I understand that I am responsible for full payment of services provided by Dr. Woodruff at the time of service. As a courtesy, paper claims and supporting documentation necessary for filing with any applicable insurance companies will be provided by Dr. Woodruff to the patient for filing. I authorize the use of my signature on all insurance submissions. Any insurance payments made to Dr. Woodruff instead of the patient will be promptly refunded to the party providing the original payment. I understand that insurance reimbursements for Dr. Woodruff's services are unpredictable in advance of services.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

MINOR/CHILD CONSENT (Child Only)

I am the parent, guardian or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and consent Dr. Woodruff's staff to perform necessary services for the child named above, including but not limited to, head, neck and intra-oral examinations, panoramic radiographs, oral dental impressions and similar services which are deemed advisable by Dr. Woodruff, whether or not I am present when the treatment is rendered. I agree to the above applicable financial guidelines.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____

Printed Name of Parent, Guardian or Personal Representative

Bruce A. Woodruff, D.M.D.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act give you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

-Treatment means providing, coordinating, or managing health care and related services by our health care providers. Examples of this would include new patient exams and follow-up visits.

-Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill to your insurance company for payment.

-Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all individually identifiable information.

We may contact you to provide appointment reminders or information about your treatment. Your office treatment notes are typically provided to your Primary Care Physician and any referring Physicians.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor by that written request, except to the extent that we have already taken actions relying on you authorizing.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 7, 2019 and we are required to abide by the terms of our Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

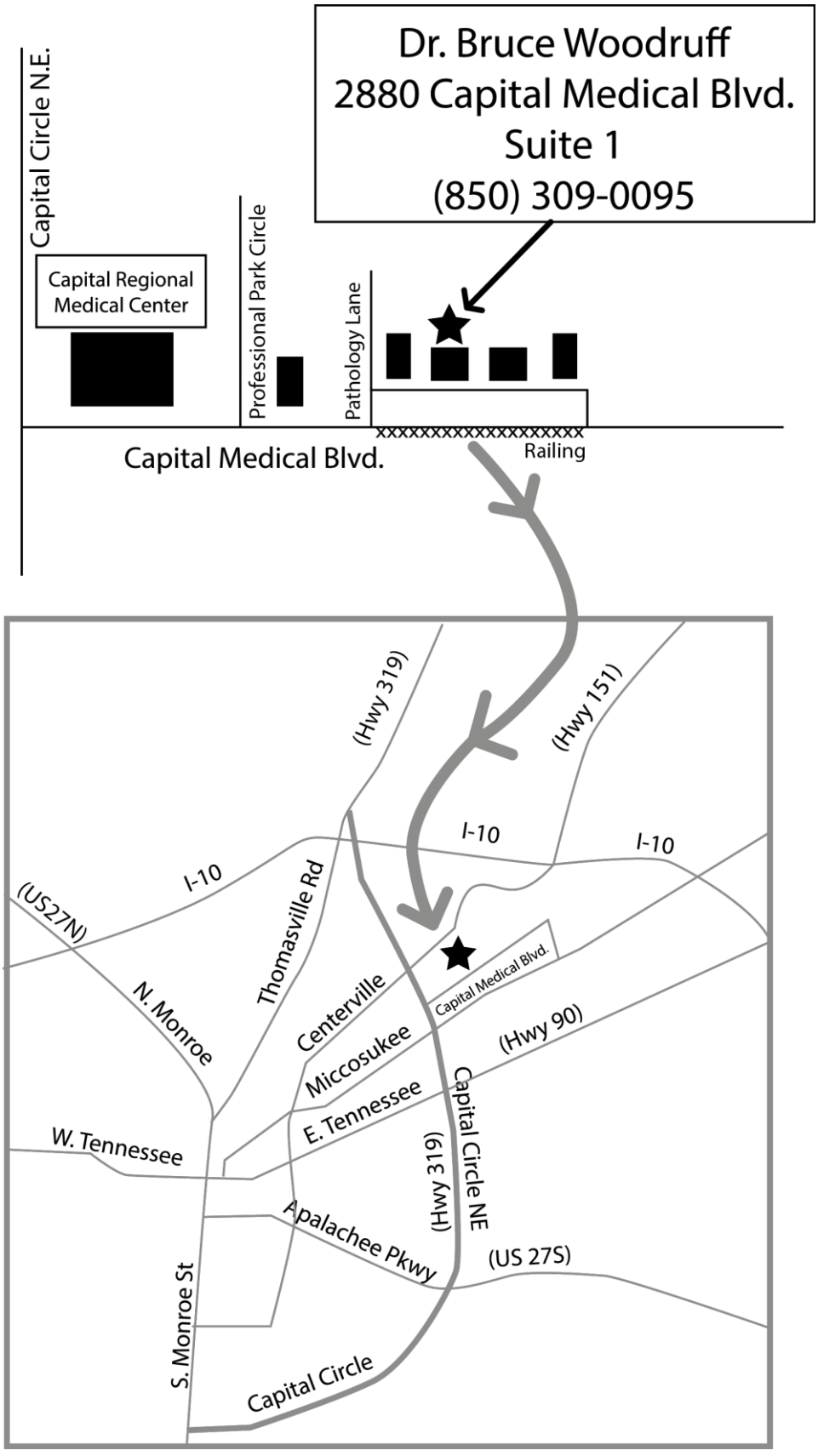
Signature:_____ Date:_____

I give permission for the person(s) and/or organization(s) listed below to obtain any and all of my medical information:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

_____ _____ _____

Date Initials Reason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(Hwy 151)
I-10
I-10
I-10
(US27N)
Thomasville Rd
N. Monroe
Centerville
Capital Medical Blvd.
Miccosukee
(Hwy 90)
E. Tennessee
W. Tennessee
Capital Circle NE
(Hwy 319)
Apalachee Pkwy
(US 27S)
S. Monroe St
Capital Circle