Galax Dental Care

Ethan Y. Jones, DDS, PC
276.236.0562
www.galaxdentalcare.com

Patient Information

Patient Name: _____ Date: _____
Last First MI Preferred

☐ Married ☐ Single ☐ Child ☐ Other ☐ Male ☐ Female

Birthdate: ____/____/____ SS#: ____-____-____ Driver's License #: _____

Address: _____
Street Apartment #

_____
City State Zip Code

E-Mail _____ Home # ( )____-____ Work # ( )____-____ Ext: ____

Mobile # ( )____-____ Other # ( )____-____ Best time to call? _____

Insurance / Employer Information

Primary Insurance

Name of Insured (Person Carrying the Insurance): _____ Birthdate: ____/____/____

Employer Name: _____ ID # or SS#: _____ Group # _____

Insurance Plan Name and Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance **Yes** **No** **(please circle)**

Consent for Services

This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that it is only a benefit and that He/She is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

If payment from your insurance company is not paid within 30 days, account unpaid balance will be your responsibility, unless previously written financial arrangements are made. Once insurance payment is made, reimbursement will be sent directly to the patient within 4 weeks.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian: _____ Date: _____

Relationship to Patient: _____ Printed name of Parent/Guardian (if applicable): _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Patient ☐ Friend ☐ Relative ☐ Referring Dentist
☐ Previous Patient ☐ Drive / Walk by ☐ School ☐ Work ☐ Galax Dental Care Web Site ☐ Yellow Pages
☐ Google ☐ Other Online Source ☐ Name of referral: _____

Health Information and History

Galax Dental Care

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

(please circle one)

1 Within the last 3 years, have you been hospitalized or had surgery? ..... Yes No

If yes, please give reason and dates: _____

2 Have you ever been instructed to take **ANY** medications, or take **ANY** special precautions before any dental treatment? ..... Yes No

If yes, please explain: _____

3 Are you taking **ANY** drugs, medications or treatments at this time? ..... Yes No
(If you brought a complete written list with you, give that to the receptionist instead)

Prescribed: _____

Over-the-counter medications (such as Aspirin, Advil, Allergy Medication, Sleeping Aids, Etc):	
Vitamins, natural or herbal preparations and/or dietary supplements:	

Are you having or have you ever had radiation or chemotherapy treatments? Yes No

If yes, for how long? _____ Name of facility performing the treatment: _____

4 Are you taking or have you ever taken/been treated with a Bisphosphonate (Fosamax)? Yes No

5 Are you allergic to or have you ever experienced an unusual reaction to:

_____ Latex _____ Metals or jewelry _____ Dental anesthesia (local)
_____ Fluoride _____ Nitrous Oxide _____ General Anesthesia

6 Are you allergic to or have you ever had any reaction to any of the following drugs?

_____ Tetracycline _____ Codeine _____ Aspirin/Ibuprofen (Advil, Motrin, Nuprin)
_____ Erythromycin _____ Iodine _____ NSAID (Celebrex, Vioxx, Anaprox)
_____ Sulfa Drugs _____ Tranquilizers (Valium) _____ Clindamycin (Cleocin)
_____ Penicillin _____ Keflex (Cephalexin)

7 Have you had an allergic reaction or unusual response to **ANY** other medications, drugs, pills, or treatments:

If Yes, please list: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City/St: _____

Other Physicians and Specialists

Name/Specialty: _____ Phone: _____ City/St: _____

Name/Specialty: _____ Phone: _____ City/St: _____

If you completed this form for another person:

Your Name: _____ Phone: _____ Relationship: _____

Continued on next page

Reviewed By: _____

Health Information and History (continued)

Galax Dental Care

8 Do you have, or have you ever had, any of the following? (please check Yes or No for each)

Congenital heart defects	Y	N	Hepatitis, jaundice, or other liver problems	Y	N
Angina or chest pains	Y	N	Morning Headaches	Y	N
Arthrosclerosis	Y	N	Any form of cancer	Y	N
Congestive Heart Failure	Y	N	An organ transplant	Y	N
Coronary artery disease	Y	N	Asthma	Y	N
Heart Surgery	Y	N	Hay fever, skin or food or general allergies	Y	N
If Yes, type and date _____			Sinus problems	Y	N
Heart Attack	Y	N	Tuberculosis, emphysema or lung disorder	Y	N
If Yes, date _____			Skin problems	Y	N
Rheumatic heart disease/ rheumatic fever	Y	N	A sore/wound that bleeds easily, doesn't heal	Y	N
Infective Endocarditis	Y	N	A thyroid problem or disease	Y	N
Heart valve damage/ Mitral valve prolapse	Y	N	Arthritis	Y	N
Artificial heart valve	Y	N	Glaucoma or any eye disease	Y	N
Pacemaker	Y	N	Epilepsy or other seizure disorder	Y	N
Stroke or CVA	Y	N	Any kidney problems	Y	N
High Blood Pressure	Y	N	Excessive Daytime Sleepiness	Y	N
Low Blood Pressure	Y	N	Use a CPAP	Y	N
Anemia	Y	N	Are you currently trying to lose weight?	Y	N
Hemophilia or bleeding disorder	Y	N	An active sexually transmitted disease (STD)	Y	N
Excessive bleeding from any cut or incident	Y	N	Any mental health issues	Y	N
Diabetes or blood sugar problems	Y	N	Been treated for any psychiatric condition	Y	N
Any artificial joint, joint surgery, or prosthesis	Y	N	**Woman Only:**		
If yes, what joint or area: _____			Are you pregnant?	Y	N
When was operation done: _____			If yes, what is your due date: _____		
Ulcers, acid reflux, or stomach problems	Y	N	Do you think you might be pregnant?	Y	N
Morning Reflux	Y	N	Are you presently nursing?	Y	N
A compromised immune system (lupus, HIV, AIDS, radiation immune problem)	Y	N	Are you using birth control medication?	Y	N
			Are you taking hormone replacement therapy?	Y	N

If you answered Yes to any of the above, please provide details here:

_____

_____

9 Do you use Tobacco? If so how often? Y N _____

10 Do you use Alcohol? If so how often? Y N _____

11 Do you use Caffeine? If so how often? Y N _____

12 Do you have any conditions, diseases, or medical problems, or is there any other information that you would like us to know about, or that we should be made aware of? **YES** **NO**

If Yes, please explain:

_____

_____

Consent To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health; or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature _____ **Date** _____

(parent or guardian, if patient is minor)

Reviewed by: _____

Galax Dental Care
Ethan Y. Jones, DDS, PC
1001 East Stuart Drive
Galax, Virginia 24333
276.236.0562
galaxdentalcare.com

Payment Policy

The payment policy of our office is that payment (co-payment if insured) is due at the time services are rendered.

Broken Appointment Policy

Our office considers any appointment that is not cancelled or rescheduled, within 24 hours of the appointed time, a broken appointment (extenuating circumstances will be taken into consideration). Once a patient or family has broken three appointments, we will no longer be able to treat their dental needs.

Signature: _____

Date: _____

Galax Dental Care

Ethan Y. Jones, DDS, PC
1001 East Stuart Drive
Galax, Virginia 24333
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Consent

I hereby authorize the staff and employees of Dr. Ethan Y. Jones' office to perform and hereby consent to such dental care, including diagnostic procedures, medical treatment and examination as may, in the opinion of my treating or attending physicians, be necessary.

I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made as to the result of any procedures, treatment, or examination.

I understand that in all confirmed cases where a health care provider, or an person employed or under the direction and control of a health care provider, is directly exposed to blood or other body fluids from a patient in a manner such as through an accidental needle stick, which may transmit human immunodeficiency virus (HIV – the virus that causes AIDS) or infectious Hepatitis B (HBV), under Virginia law, a patient will be deemed to have consented to testing for HIV and to the release of such test results to the person who is exposed. Positive test results will also be disclosed as medically necessary in connection with the patient's medical treatment or as required or permitted by law. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling.

The reverse of this law also applies. Any time a patient is directly exposed to blood or body fluids of a health care worker, the worker is deemed to have consented to testing for HIV infection and to the release of such test results to the patient.

Signature _____

Date _____

Witness _____

Galax Dental Care

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Galax Dental Care** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices by **Galax Dental Care** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Galax Dental Care** reserves 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 Lorrie Sexton, 1001 E. Stuart Drive, Galax, VA 24333.

With this consent, **Galax Dental Care** may call my home or other alternate location and leave a message on voice mail 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 test results, among others.

With this consent, **Galax Dental Care** may mail (or e-mail) to my home or other alternate 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 Galax Dental Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by said agreement.

By signing this form, I am consenting to allow **Galax Dental Care** to use and disclose 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, Galax Dental Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Patient's Printed Name _____ Date _____

Print Name of Patient or Legal Guardian, if applicable _____

HIPAA EMAIL CONSENT

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email.
- **When we send or receive an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received or sent, someone may be able to access the email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a PDF (page 5634) on the U.S. Department of Health and Human Services website http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines stated that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to have dental information including x-rays sent via email, then a dental entity may send personal dental information via unencrypted email.

OPTION 1 – **ALLOW** UNENCRYPTED EMAILS

I understand the risks of unencrypted emails and do hereby give permission to Ethan, Y. Jones, DDS, PC to send dental information via unencrypted email to any dental professional that he has referred me to or that I have requested my records be sent.

_____	_____	_____
Signature (Parent or Guardian, if minor)	Date	Printed Name

OPTION 2 – **DO NOT ALLOW** UNENCRYTED EMAILS

I do not wish for my dental information to be sent via email.

_____	_____	_____
Signature (Parent or Guardian, if minor)	Date	Printed Name

Galax Dental Care

Ethan Y. Jones, DDS, PC
1001 East Stuart Drive
Galax, Virginia 24333
276.236.0562
galaxdental@gmail.com

Consent for Release of Dental Records

I, _____, do hereby consent to and authorize
(print patient name here)

_____, _____ located in _____
(name of previous dentist/provider) **(telephone)** **(city/state)**

to disclose to Galax Dental Care, Dr. Ethan Y. Jones, 1001 E. Stuart Drive, Galax, VA 24333, information regarding my dental records, including current and previous records which are relevant as part of my dental record.

My date of birth is _____, and my social security number is **XXX-XX-**_____.
This information is strictly for purposes of identification.

Patient or Parent/Guardian Signature _____

Date _____

Printed Name of Parent/Guardian _____

Relationship to Patient _____