

**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



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):	_____
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Vitamins, natural or herbal preparations and/or dietary supplements:	_____
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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: \_\_\_\_\_

## Health Information and History (continued)

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
Angina or chest pains	Y	N
Arthrosclerosis	Y	N
Congestive Heart Failure	Y	N
Coronary artery disease	Y	N
Heart Surgery	Y	N
If Yes, type and date _____		
Heart Attack	Y	N
If Yes, date _____		
Rheumatic heart disease/ rheumatic fever	Y	N
Infective Endocarditis	Y	N
Heart valve damage/ Mitral valve prolapse	Y	N
Artificial heart valve	Y	N
Pacemaker	Y	N
Stroke or CVA	Y	N
High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Anemia	Y	N
Hemophilia or bleeding disorder	Y	N
Excessive bleeding from any cut or incident	Y	N
Diabetes or blood sugar problems	Y	N
Any artificial joint, joint surgery, or prosthesis	Y	N
If yes, what joint or area: _____		
When was operation done: _____		
Ulcers, acid reflux, or stomach problems	Y	N
Morning Reflux	Y	N
A compromised immune system (lupus, HIV, AIDS, radiation immune problem)	Y	N

Hepatitis, jaundice, or other liver problems	Y	N
Morning Headaches	Y	N
Any form of cancer	Y	N
An organ transplant	Y	N
Asthma	Y	N
Hay fever, skin or food or general allergies	Y	N
Sinus problems	Y	N
Tuberculosis, emphysema or lung disorder	Y	N
Skin problems	Y	N
A sore/wound that bleeds easily, doesn't heal	Y	N
A thyroid problem or disease	Y	N
Arthritis	Y	N
Glaucoma or any eye disease	Y	N
Epilepsy or other seizure disorder	Y	N
Any kidney problems	Y	N
Excessive Daytime Sleepiness	Y	N
Use a CPAP	Y	N
Are you currently trying to lose weight?	Y	N
An active sexually transmitted disease (STD)	Y	N
Any mental health issues	Y	N
Been treated for any psychiatric condition	Y	N
<b>Woman Only:</b>		
Are you pregnant?	Y	N
If yes, what is your due date: _____		
Do you think you might be pregnant?	Y	N
Are you presently nursing?	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:

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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:

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**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** \_\_\_\_\_  
(parent or guardian, if patient is minor)

**Date** \_\_\_\_\_

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

276.236.0562

galaxdentalcare.com



## 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 a 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

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



## 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 UNENCRYPTED 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 \_\_\_\_\_



# Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

**One American dies every hour from oral cancer.** Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such life style risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. \* Oral cancer risk by patient profile as follows:

<b>Increased risk:</b>	patients ages 18-39 -sexually active patients (HPV)
<b>High risk:</b>	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
<b>Highest risk:</b>	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope powered by Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is ~~\$89.00~~. *\*included with initial comprehensive exam (no fee).*

- Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.
- No. I would prefer not to have the VELscope powered by Sapphire exam at this time.

Print Name \_\_\_\_\_

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

