# Welcome to our Office
# Randall C. Jones, DMD, LLC

Thank you for choosing Dr. Randall C. Jones as your dental provider. We appreciate the opportunity to take care of your dental needs. Our team of dedicated, knowledgeable and skilled staff is committed to providing you with excellent care in a warm and caring environment.

## Office Hours

Our office hours are Tuesday through Thursday from 8:00 a.m. to 5:00 p.m. and Fridays from 8:00 a.m. to 3:00 p.m. We are closed for lunch from 1:00 p.m. to 2:00 p.m.

## Scheduling Appointments

At your initial appointment you can expect a full comprehensive exam and any necessary x-rays. Cleaning and treatment appointments can be scheduled once your initial exam is done. If a cleaning appointment is available, after your initial exam, the appointment may be offered to you. It is important to schedule your appointments in advance, to ensure a time that best fits your scheduling needs. We ask that you arrive 15 minutes before your appointed time for check in, so that we may begin treatment, at the appointed time. If you are not here at your appointed time your appointment may be offered to someone else or if you are 10 minutes late, your appointment most likely will be rescheduled, unless the doctor's schedule can accommodate you.

**Note: Patients under the age of 16 must be accompanied by a parent or guardian to all appointments.**

**Initial _____**

## Missed or Broken Appointments

Once an appointment has been made, that time is reserved specifically for you. If you are unable to keep your appointment, we ask that you call our office as soon as possible. We require 24 hour advanced notice for all cancelled appointments. We reserve the right to charge a $50.00, No Show or Broken appointment Fee, as well as possible dismissal from our practice for repeat offenses or at the clinics discretion. If calling after hours, please leave a message on the answering machine and we will get back to you on the next regular business day.

**Initial _____**

## Dental Emergencies

Please call during regular business hours, if at all possible. We will do our best to work you into the schedule and take care of you. Space and time slots may be limited. In the case of a dental emergency after hours, you may reach the Doctor at the emergency contact number stated on the message machine. For after hour emergency treatment (evening/weekend) we reserve the right to charge an additional fee to offset the doctor and staff time. Many insurance plans do not pay for after hours appointments and therefore the fee is patient responsibility.

**Initial _____**

## Dental Insurance

Our office is committed to helping our patients maximize their dental benefits. We do a complimentary benefit check, and as a courtesy to our patients, we will file your dental claim forms. Verification of dental benefits is not a guarantee of coverage. Co–pays are due at the time services are rendered and are an estimate of coverage. Some procedures are not covered by insurance and some procedures may go through an insurance review board. Any procedure not covered by insurance or any amount left owing, after the insurance company has made its final payment, is the responsibility of the patient, unless otherwise stated on the insurance explanation of benefits.

Date_____ **Initial _____**

## Crowns and removable appliances

Crowns, bridges, fixed and removable appliances are made by an outside dental laboratory. These procedures take time to prepare, produce and install. In many cases this requires multiple appointments. You are responsible for returning to our office to receive the appliance. If you do not return, you will be liable for the full amount of the appliance and possible lab fee, regardless of your insurance company. This notice also includes state insurance, such as OHP. Insurance does not pay until and appliance is delivered. This section serves as a client agreement to pay for services (OHP) in this situation. There is a 50% deposit required at the time of the first impression.

**Initial** _____

## Payments

Payments are due, in full at the time of service. If dentures, partials, bridges or crowns are to be fabricated by a dental laboratory, we require a 50% deposit at the time of the first impression. Failure to return to our office, within 30 days, for the delivery of any dental appliance, compromise the fit and function of said appliance and the patient will be charged for any and all lab fees incurred. These fees are not billable to insurance. We accept all forms of payment. Cash, Visa, Mastercard, Discover, American Express and Checks. There is a $35.00 returned check fee, added to your account, for returned checks. Monthly payment options are available through Care Credit Financial.

**Initial** _____

## Outstanding Balances

Outstanding balances are discouraged and must be cleared before the next appointment for any account member or within 30 days of treatment. Amount due and not paid in full within 30 days may be charged a fee. Delinquent accounts over 90 days may be referred to a collection agency. In the event that your account is referred to a collection agency, your account balance must be paid, prior to any dental treatment being rendered, except on an emergency basis.

**Initial** _____

We ask that you keep our office up to date of any address and/or phone number changes. Confirmation and reminders of your appointments are complimentary and necessary. Sometimes situations arise or changes need to be made and it is imperative that all patients are reachable.

I have read, and accept the policies listed above and agree to abide by the terms and conditions.

X _____ Date _____

Signature of Patient / Guardian

{Randall C. Jones D.M.D, LLC.}

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Social Security Number: _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Crystal Miranda

Telephone: 503-838-0434 Fax: 503-838-4751

E-mail: drjonesdentistry@hotmail.com

Address: 1004 Monmouth St., Independence, OR 97351

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. In the event that I request my health care records via email, I understand that there is some level of risk involved with electronic transmitting, such as the email being read or intercepted by a third party while in transit. Office email is unencrypted. If the information becomes compromised during transmitting, HIPPA does not require that the patient or federal government be notified if there is a breach.

Signature:_____ Date: _____

**If** this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



**This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).**

# Dr. Randall C. Jones DMD, LLC

1004 Monmouth St. Independence, OR 97351
503-838-0434

**Patient Information**

Name:_____DOB_____/_____/_____ Male ☐ Female ☐
Last First Middle
SSN ---------- _____
Local Address:_____City:_____State:_____Zip:_____
Mailing Address(if different):_____
Primary Phone:_____Secondary Phone:_____Work Phone:_____
Email Address:_____
Patient Employer/School:_____
Phone:_____
Employer/School Address:_____
Occupation:_____

Marital Status: Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered ☐ for_____years
Spouse's Name:_____Spouse's Employer:_____

Whom may we thank for referring you?_____

**Responsible Party Information**

Name:_____SSN: ---------- _____DOB:_____/_____/_____
Relation:_____
Local Address:_____City:_____State:_____Zip:_____
Mailing Address(if different):_____
Primary Phone:_____Secondary Phone:_____Work Phone:_____

**Emergency Contact: Person to contact other than parent/spouse**

Name:_____Relationship:_____
Phone:_____Secondary Phone:_____

**Primary Insurance:**
Name of Insured:_____
Insured DOB:_____/_____/_____
Relationship to Patient:_____
Member ID#:_____
Group#:_____
Employer:_____
Name of Insurance Company:_____
Insurance Phone Number:_____
Insurance Mailing Address:_____
_____

**Secondary Insurance:**
Name of Insured:_____
Insured DOB:_____/_____/_____
Relationship to Patient:_____
Member ID#:_____
Group#:_____
Employer:_____
Name of Insurance Company:_____
Insurance Phone Number:_____
Insurance Mailing Address:_____
_____

I authorize the release of this information including diagnoses and records of any treatment or examination rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and claim submission and reimbursement assigned directly to Dr. Randall C Jones DMD LLC any insurance benefit to which I am entitled. I also understand that based on the services rendered I am financially responsible for this account, including service fees or finance charges for overdue balances and missed appointments, and that I am required to pay for my services.

Signature of Patient (18 or older):_____Date:_____
Signature of Parent or Guardian:_____Date:_____

# Dr. Randall C. Jones DMD LLC

## HEALTH HISTORY

## ALL INFORMATION IS KEPT CONFIDENTIAL

**Please Print Patient Name**:_____ **DOB**___/___/_____

Primary Care Doctor:_____ Primary Care Phone:_____

Pharmacy:_____

**Answer all questions by circling Yes (Y) or No (N):**

1. Do you consider yourself to be in good health?..... Y N
2. Has there been any change in your general health in the past two years?..... Y N
3. When did you last see your doctor?_____
4. Are you now under a physician's care for a particular problem?..... Y N
   If yes, please describe:_____
5. Have you ever had any serious illnesses, operations, hospitalizations?..... Y N
6. **DO YOU HAVE OR HAVE YOU HAD:**
   * Rheumatic Fever or Rheumatic Heart Disease?..... Y N
   * Cardiovascular Disease (heart attack, angina, heart trouble, heart murmur, coronary artery disease attack, heart palpitations, heart surgery, pacemaker?..... Y N
   * Stroke?..... Y N
   * High Blood Pressure?..... Y N
   * Lung Disease: Asthma, chronic cough, Bronchitis, Pneumonia?..... Y N
   * Tuberculosis?..... Y N
   * Shortness of Breath?..... Y N
   * Chest Pain?..... Y N
   * Seizures, convulsions, Epilepsy?..... Y N
   * Fainting or dizziness?..... Y N
   * Bleeding disorder, anemia, blood transfusion, or bleeding tendencies?..... Y N
   * Do you bruise easily?..... Y N
   * Liver Disease ?.....Type?_____..... Y N
   * Diabetes?.....Type?_____..... Y N
   * Kidney Disease?..... Y N
   * Thyroid Disease (goiter)?..... Y N
   * Arthritis?..... Y N
   * Stomach Ulcers or Colitis?..... Y N
   * Glaucoma?..... Y N
   * Sinus or Nasal problems?..... Y N
   * Tumor or growth on head or neck?..... Y N
   * Cancer? ..... Y N
     Type?:_____
   * Chemotherapy?..... Y N
   * Radiation (Xray) treatment for cancer?..... Y N
   * Any diseases or transplant operation that has depressed the immune system?..... Y N
     Type?:_____
   * AIDS/HIV?..... Y N
   * Implants or artificial joints placed anywhere in your body (heart valve, pace maker, hip, knee)?..... Y N
     If yes, what and when?_____
   * Swollen feet or ankles?..... Y N
   * Swollen neck glands?..... Y N
   * Nervous problems?..... Y N
   * Psychiatric care?..... Y N
   * Venereal Disease?..... Y N
   * Weight Loss- unexplained?..... Y N
   * Ulcer?..... Y N
   * Migraines?..... Y N
   * Do you wear contact lenses?..... Y N

7. **ARE YOU USING ANY OF THE FOLLOWING?:**
   * Antibiotics?.....Type_____ Y N
   * Anticoagulants (blood thinners) ?..... Y N
     If yes, what is your most recent INR number?_____
   * Aspirin or drugs such as Aleve, Ibuprofen?..... Y N
   * High Blood Pressure medication?..... Y N
   * Steroids (Cortizone, Prednizone, etc)?..... Y N
   * Tranquilizers?..... Y N
   * Insulin or a diabetic drug?..... Y N
   * Digitalis, Inderal, Nitroglycerin or other heart drug?.... Y N
   * Bisphonate (Aredia, Zometa, Actonel, Boniva, Fosomax, Skelid, Didronel)?..... Y N
   * Have you ever taken any of the group of drugs collectively referred to as "phen phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexenfluramine)?..... Y N

**PLEASE LIST ANY MEDICATIONS TAKEN, INCLUDING PRESCRIPTION, OVER-THE-COUNTER, HERBAL OR HOLISTIC REMEDIES, VITAMINS OR MINERALS:**

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AND ADVERSE REACTION TO:** CIRCLE ALL THAT APPLY

| | |
|---|---|
| Local anesthesia (Novacaine, etc) | Penicillin or other antibiotic |
| Sedatives, Barbiturates, Sulfites | Aspirin or Ibuprofen |
| Codeine or other pain killers | Latex or Rubber |

* Any other allergies or reactions?..... Y N
  If yes, please list:_____
9. Do you smoke or use chewing tobacco or have you in the past?..... Y N
10. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?..... Y N
11. Do you use recreational drugs?..... Y N
12. Do you have any other disease, condition or problem you think the doctor should know about?.... Y N
    If yes, please list:_____
13. **WOMEN ONLY:**
    * Are you pregnant?.....Due Date?_____ Y N
    * Are you nursing?..... Y N
    * Using birth control?..... Y N
    If yes, please list what type:_____

*If you are on Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore; you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your medical physician for further guidance.*

**I understand the importance of truthful Health History to assist the doctor in providing the best care possible**

Signature of Person Completing Health History:_____ Date:___/___/___

Print Name of Person Completing Health History:_____

**Dr. Randall C. Jones DMD, LLC**
1004 Monmouth St. Independence, OR 97351
503-838-0434

# Dental History

**Patient Name:**_____ **Date:**_____
**Reason for today's visit:**_____
**Former Dentist:**_____ **City/State:**_____
**Date of Last Dental Visit:**_____
**Date of Last Dental X-rays:**_____

Circle Y "yes" or N "no" to indicate if have had any of the following:

| | | |
|---|---|---|
| * Bad Breath..... | Y | N |
| * Bleeding Gums..... | Y | N |
| * Blisters on Lips or Mouth..... | Y | N |
| * Burning Sensation on Tongue..... | Y | N |
| * Chew On One Side of Mouth..... | Y | N |
| * Cigarette, Pipe, or Cigar Smoking Currently..... | Y | N |
| * Cigarette, Pipe or Cigar Smoking in the Past..... | Y | N |
| *Clicking or Popping of Jaw..... | Y | N |
| * Dry Mouth..... | Y | N |
| * Fingernail Biting..... | Y | N |
| * Foreign Objects in Mouth..... | Y | N |
| * Grinding Teeth..... | Y | N |
| * Gums Swollen or Tender ..... | Y | N |
| * Jaw Pain or Tiredness..... | Y | N |
| * Lip or Cheek Biting..... | Y | N |
| * Loose or Broken Fillings..... | Y | N |
| * Mouth Breathing..... | Y | N |
| * Mouth Pain while Brushing..... | Y | N |
| * Pain Near Ear..... | Y | N |
| * Sores or Growths in Your Mouth..... | Y | N |
| * Orthodontic Treatment – Date_____..... | Y | N |
| * Periodontal Treatment – Date_____..... | Y | N |
| * Sensitivity to Cold - Location_____ | Y | N |
| * Sensitivity to Heat - Location_____ | Y | N |
| * Sensitivity to Sweets - Location_____ | Y | N |
| * Sensitivity When Biting – Location_____ | Y | N |
| * Sleep Apnea ..... | Y | N |

How Often Do You Floss?_____
How Often Do You Brush?_____
Please List Any Other Dental Concerns:_____
_____