

New Patient Consent Form

Texas Mobile Dentists provides on-site mobile dentistry solutions. We provide care to our patients in various environments including assisted living facilities, nursing homes, group homes, and personal residences. Our clinicians provide a full-suite of services including exams, low dose x-rays, prophylaxis cleanings, fluoride treatments, fillings, extractions, crowns, partials, dentures, and much more!

THE FIRST VISIT AND WHAT TO EXPECT

A new patient typically receives an initial comprehensive dental examination with oral cancer screening (\$106), x-rays (\$88), and cleaning with fluoride treatment (\$190). The patient must receive an exam to become a patient of record and to be seen for a cleaning by the hygienist. The doctor will complete a thorough review of the patient’s current oral status and outline any needed treatment at the first appointment. Any treatment recommendations will be communicated & sent via email/mail to the patient or healthcare guardian for approval. After a treatment plan is signed, the manager will coordinate with you to schedule the treatment visit.

PRICING

Pricing at Texas Mobile Dentists is competitive with traditional practices and more convenient for the patient.

Initial Comprehensive Dental Examination	\$106	Cleaning with Fluoride Treatment	\$190
Low Dose X-rays (4 decay disclosing x-rays)	\$88	Cleaning without Fluoride	\$143

All fees are subject to change. A home visit fee will be applied for each visit if the location of service is a personal residence (not a community).

LEVEL OF CARE SELECTIONS AND FREQUENCY

The elderly, especially those with any type of cognitive impairment like dementia, are at increased risk for caries, periodontal disease, and oral infection because of use of medications that produce xerostomia (dry mouth) and loss of manual dexterity that prevents maintaining oral health daily. It is critically important for patients over the age of 65 to receive consistent, recurring exams, cleanings, and fluoride treatments. Read more from the American Dental Association about dental care for the elderly at this link: <http://www.ada.org/en/member-center/oral-health-topics/aging-and-dental-health>.

Exams	Exams occur every 6 months unless otherwise requested. The initial new patient exam is \$106. All follow-up routine periodic exams are \$87.
Low Dose X-rays	Low dose x-rays are required for all new patients. X-rays are taken every 6 months. We have established this as our standard of care because the senior population is at high risk of oral disease. Edentulous patients are exempt from x-rays.
Cleanings (Prophylaxis)	A dental prophylaxis performed by a dental hygienist includes scaling and/or polishing procedures to remove coronal plaque, calculus, and stains. Cleanings typically happen a few days after the exam! <input type="radio"/> Every 3 months [Recommended] <input type="radio"/> Every 6 months <input type="radio"/> No cleanings
Fluoride Opt Out	<input type="checkbox"/> Check here to opt out of fluoride treatments (\$47). I do not wish for the patient to receive fluoride treatments. I understand fluoride treatments are recommended by the American Dental Association and help prevent tooth decay in the elderly.
Hygiene Therapy Program (HTP) - only for participating facility partners	HTP is a weekly toothbrushing, flossing, denture check, and hygiene instruction program completed by a Dental Assistant. This supplemental program (doesn't replace regular Prophylaxis Cleanings) was created at the request of families and communities to improve the patient's oral hygiene status. Patients enrolled in this program will receive 15% off all treatment (excludes exams and cleanings)! <input type="radio"/> No <input type="radio"/> Yes if available (\$39 per week) <input type="radio"/> Maybe - I'd like to learn more

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

The person filling out this form is the: Patient Full POA or Medical POA Financial POA Other _____

The patient currently resides in a: Community/Facility Personal Residence

Gender _____ Community/Facility Name (if applicable): _____ Room # _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Email _____

PRIMARY RESPONSIBLE PARTY / MEDICAL POWER OF ATTORNEY (IF APPLICABLE)

First Name _____ Last Name _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Telephone (Home) _____ Telephone (Cell) _____
 Email _____ Relation to the Patient _____

FINANCIAL POWER OF ATTORNEY (IF APPLICABLE AND DIFFERENT FROM ABOVE)

First Name _____ Last Name _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Telephone (Home) _____ Telephone (Cell) _____
 Email _____ Relation to the Patient _____

PATIENT MEDICAL HISTORY (CHECK IF THE PATIENT HAS OR HAS EVER HAD)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies, hay fever, sinusitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Slow healing wounds |
| <input type="checkbox"/> Artificial joints; Surgery Date: _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Bleeding abnormally with operations or surgery | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood disease, clotting disorders | <input type="checkbox"/> Any immune deficiency | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tumor or growth on head/neck |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Weight loss, unexplained |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Osteopenia | Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergic to Aspirin |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Radiation treatments (specify if head/neck) | <input type="checkbox"/> Allergic to Penicillin |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Allergic to latex |
| <input type="checkbox"/> Fainting or fall risk | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Allergic reaction to Novocaine, local, or general anesthetics? |
| | <input type="checkbox"/> Scarlet fever | |

If "Yes" to any of the above, please describe: _____

Is the patient currently taking prescription blood thinners? Yes No Uncertain If "Yes", specify _____

Has the patient ever taken medications or received injections for osteoporosis (bisphosphonates)? Yes No Uncertain

Has the patient ever been prescribed pre-medication for a dental visit? Yes No

List any medications that the patient is taking: _____

List any known allergies the patient has: _____

Does the patient have a DNR or on-file with the community? (if applicable) Yes No Uncertain

Primary Care Physician / MD: _____ Contact Information: _____

DENTAL HISTORY

Is the patient responsible for his/her own brushing and flossing? Yes No

Does the patient wear dentures (complete or partials)? Yes No

Date of the last dental exam? _____ Date of the last dental x-rays? _____

Main concern for dental visit (optional) _____

OTHER INFORMATION

Please provide any other details you would like to us know: _____

How did you hear about us? _____

AUTHORIZATION AND RELEASE

This dental consent may be withdrawn at any time. The patient, legal guardian, or healthcare surrogate, if any, authorizes the attending doctor and dental team from Texas Mobile Dentists to review existing medical records, examine, and provide dental care, if necessary, to the named patient. The patient, legal guardian, or health surrogate, if any, has read and fully understands the General Dental Informed Consent and HIPAA Notice of Privacy Practices. No guarantee or assurance has been made to the patient, legal guardian, or healthcare surrogate, if any, concerning the results, which may be obtained. The patient, legal guardian, or healthcare surrogate, if any, authorizes the attending doctor to provide continued care on the following schedule until dental consent is withdrawn. The patient, legal guardian, or healthcare surrogate, will be notified of any required restorative treatment, based on examination results. Texas Mobile Dentists will not perform any restorative treatment without written approval from the patient/POA.

By signing below, you are acknowledging that:

- You are either the patient or have full financial and medical legal decision-making capability for the named patient.
- You have read and agreed to the General Dental Informed Consent (page 5). A current copy of the General Dental Informed Consent is also posted on our website for your reference.
- If applicable, you give the care community explicit consent to share patient health information (medical history, medication lists, responsible party information) with us as the patient’s healthcare provider. You also allow Texas Mobile Dentists to send patient information, notes, and post-op information to the care community to facilitate continuity of the patient’s overall care and well-being.
- You consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, and health care operations.

SIGN HERE → Signature: _____ Date: _____

PRIVACY POLICY CONSENT

Purpose of Consent: You will consent to our use and disclosure of the patient’s protected health information to carry out treatment payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the 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. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices at any time by visiting our website, emailing info@texasmobiledentists.com, or calling (512) 428-8863. You may reach out to the Privacy Officer, Ben Tiggelaar, at ben@texasmobiledentists.com. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person above.

SIGN HERE → Signature: _____ Date: _____

DENTAL INSURANCE (WE SUBMIT FOR YOU AS AN OUT-OF-NETWORK PROVIDER)

We will submit your dental claim electronically on your behalf directly to the insurer as a courtesy. The entire account balance must be paid by you as we do not collect payments directly from the insurer as an out-of-network dental provider. Any insurer payments will be sent directly to the subscriber.

Group No/Name _____ Employer Name _____
Insurance Name _____ Insurance Phone # _____
Subscriber First Name _____ Subscriber Last Name _____
Subscriber Address _____ City _____ State _____ Zip _____
Subscriber Birth Date (mm/dd/yyyy) _____ Subscriber ID _____
Relation to Patient _____
Was this dental plan packaged with a Medicare Advantage/Supplement health plan? Yes No

FINANCIAL DISCLOSURES

- We accept checks, credit cards, and ACH payments, and Care Credit
- We are a private-pay out-of-network provider
- Medicaid – We do not accept Medicaid
- Medicare – Medicare does not cover the cost of any dental services
- Backup financial information in the form of a credit card or ACH information is required for treatment greater than \$500
- A 5% late fee will be applied to any outstanding balance not paid within 30 days of services being rendered

PICK ONE OF THE FOLLOWING PAYMENT OPTIONS:

OPTION 1

CREDIT CARD (WE WILL SEND YOU A RECEIPT)

Credit Card Number _____ Expiration Date (MM/YY) _____ Security Code _____
Name on Credit Card (exactly as it appears) _____
Billing Address _____ City _____ State _____ Zip _____

OPTION 2

ACH (WE WILL SEND YOU A RECEIPT)

Bank / Depository Name _____ City, State _____
ACH Routing Number _____ Account Number _____
Name on Account _____

GENERAL DENTAL INFORMED CONSENT

We would like for the patient/POA to have general knowledge of dental procedures. We ask that you review the procedures listed and want you to know that we will have you sign an informed consent prior to each dental procedure. A treatment plan for all restorative work, which includes estimated fees and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Low Dose X-rays:** Low dose x-rays are an important tool to aid the dentist in detecting potential issues and disease not visible to the naked eye. We utilize protective shields and aprons for patient safety. Low dose x-rays are required for all new patients of record and will be taken every 6 months.
2. **Drugs and Medication:** Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or prophylactic shock (severe allergic reaction).
3. **Changes in Treatment:** During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The presence of dental tooth decay, gum disease, or any dental infection has been shown to affect many other body parts, such as joints and the heart, so it is important to treat any dental infection as soon as possible.
4. **Local Anesthesia:** Local anesthesia may affect your body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various allergic reactions potentially requiring hospitalization. Injury to the nerves that can result in pain, numbness, or tingling to the chin, lip, cheek, gums, or tongue may be present for weeks, months and rarely be permanent.
5. **Fillings:** In some situations, more extensive restoration than originally planned may be required due to additional conditions discovered during tooth preparation. Significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. If the tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. Fillings may require periodic replacement with additional fillings and/or crowns.
6. **Extractions:** Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc.) The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization may be needed if complications arise during or following treatment which would be your financial responsibility.
7. **Crowns and Bridges:** Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily so avoid sticky food and candies. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown, or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
8. **Dentures (complete and partials):** Removable prosthetic appliances include risks and possible failures. This includes gum tissue pressure, jaw ridges not providing adequate support and/or retention, excessive saliva or excessive dryness of the mouth, and general psychological, behavioral, and physical problems interfering with success. We are not responsible for failures of these types. Breakage is possible by dropping the dentures or chewing on foods that are excessively hard. Full dentures become loose when there is a change in gum tissues. Our obligation is to create a functioning, well fitting device. Patients must wear the device consistently in order for the dentist to make appropriate and accurate adjustments. Any denture fit issues must be brought to our attention within 30 days of the final denture delivery. Adjustments after 30 days are an additional charge. No refunds/cancellations are possible after the case has been sent to the lab for final processing.
9. **Immediate/Interim Dentures:** After the extractions and delivery of the prefabricated immediate denture, there is fast bone loss resulting in space between the dentures and gums. This leads to rapidly increasing looseness and sore spots which must be adjusted frequently. The dentist may recommend a soft or hard relines (additional charge) if the patient experiences discomfort during the healing period to improve fit.
10. **Endodontic Treatment (Root Canal):** There is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment and occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. Occasionally additional surgical procedures may be necessary following root canal treatment.
11. **Periodontal Loss (Tissue & Bone):** This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth.
12. **Complaints:** Please contact us directly at (512) 428-8863 or email info@texasmobiledentists.com with any complaints or issues. A manager will handle the complaint and address any issue you may have to your satisfaction. Complaints concerning dental services can be directed to: Texas State Board of Dental Examiners, 333 Guadalupe Tower 3, Suite 800, Austin, Texas 78701-3942 or by calling (512) 463-6400.
13. **Community Liability:** The community where patient resides is not responsible in any way for services provided.