CMD Caring Mobile Dental

Phone: (303) 209-1829
Fax: (720) 446-3517
Email: info@caringmobiledental.com

New Patient Consent Form

Caring Mobile Dental provides on-site mobile dentistry solutions. We provide care to our patients in various environments including assisted living facilities, memory care units, nursing homes, group homes, and personal residences. Our clinicians provide a full-suite of services including exams, x-rays, prophylaxis cleanings, fluoride, 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 ($102), x-rays ($85), and cleaning with fluoride treatment ($183). 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 to the patient or healthcare guardian for approval.

PRICING

Pricing at Caring Mobile Dental is competitive with traditional practices and more convenient for the patient.

Initial Comprehensive Dental Examination $102
Low Dose X-rays (4 decay disclosing x-rays) . . . $85
Cleaning with Fluoride Treatment. $183
Cleaning without Fluoride $138

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). If we are unable to complete a full exam due to compliance, we will assess a $187 flat fee instead of the exam and x-ray dental codes listed above.

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 $102, but follow-up periodic exams are only $67.
Low Dose X-rays	Low dose x-rays are required for all new patients. X-rays are taken, at a minimum, every 12 months after that.
Cleanings (select one)	○ Every 3 months [Recommended] ○ Every 6 months ○ No cleanings
Fluoride	☐ Check here to opt out of fluoride treatments. I understand fluoride treatments are recommended by the American Dental Association and help prevent tooth decay in the elderly.

Additional requests or notes (e.g. monthly cleanings): _____

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 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 _____

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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 _____

DENTAL HISTORY

How frequently does the patient brush? _____ How frequently does the patient floss? _____

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

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

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

Prior Dentist _____ Prior Dentist Phone Number _____

Main concern for dental visit (optional) _____

_____

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

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

<u>Allergies</u>
☐ Allergic to Asprin
☐ Allergic to Penicillin
☐ Allergic to latex
☐ Allergic reaction to Novocaine, local, or general anesthetics?

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

_____

_____

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

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

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

List any medications that the patient is taking: _____

_____

_____

List any known allergies the patient has: _____

_____

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

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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 Caring Mobile Dental 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. Caring Mobile Dental will not perform any restorative treatment without verbal or 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.
- 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@caringmobiledental.com, or calling (303) 209-1829. You may reach out to the Privacy Officer, Ben Tiggelaar, at ben@caringmobiledental.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: _____

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FINANCIAL POLICY CONSENT

- Full payment is due at the time of service
- We accept checks, credit cards, and ACH payments
- We are a private-pay out-of-network provider
- We do not file insurance claims on your behalf, however we are happy to provide an insurance claim form so that you can get reimbursed if the plan provides out-of-network benefits.
- 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

PICK **ONE** OF THE FOLLOWING PAYMENT OPTIONS:

OPTION 1

CREDIT CARD (ALL MAJOR CARDS ACCEPTED)

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 PAYMENT INFORMATION

Bank / Depository Name _____ City, State _____

ACH Routing Number _____ Account Number _____

Name on Account _____

OPTION 3

BILL ME

Send me a bill through (choose one):

Email _____

Mail: Address _____ City _____ State _____ Zip _____

PAYMENT DISCLOSURES:

Credit Card: I authorize you to charge my bill directly to the credit card listed above. This authorization is valid until I provide you with written cancellation. This Credit Card Authorization Form will allow Caring Mobile Dental to process the above credit card for dental treatment. This approval form will be kept on file, kept private and confidential, and only needs to be submitted again if your account information changes. This will be an automated payment following the delivery of service. As payment amounts may vary, I will receive written notification of the amount and date of the next charge for each transaction.

ACH Payment: I hereby authorize Caring Mobile Dental to initiate debit entries to my checking/savings account indicated below at the depository financial institution named below and to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority is to remain in full force and effect until Caring Mobile Dental has received written notification from me of its termination in such time and in such manner as to afford Company and depository a reasonable opportunity to act on it. By signing below, I authorize Caring Mobile Dental to initiate an electronic debit entry to the account listed above for ONLY the dental treatment provided. All information will be kept private and confidential.

SIGN HERE → Signature: _____ Date: _____

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GENERAL DENTAL INFORMED CONSENT

Caring Mobile Dental 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 annually after that.

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 anaphylactic 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 most common being root canal therapy following routine restorative procedures. 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. Removal of Teeth: 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 (paresthesia) 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.

5. 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. 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.

6. 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 phycological and physical problems interfering with success. 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 the patient's gum tissues. We want a patient to understand the gum tissue in the plastic denture does not change. The cost for a denture re-line is an additional fee. Any denture issues must be brought to our attention within 30 days of the final denture delivery.

7. 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 (apicoectomy).

8. Periodontal Loss (Tissue & Bone): This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacements, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal condition.

9. Implants: They are a permanent alternative to bridges, partials or dentures. This process involves the participation of an oral surgeon. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.

10. Sealants: There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years as long as the patient is seen twice a year for exam and prophylaxis cleaning visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them completed.

11. Sedative Fillings: Sedative fillings are temporarily. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 6-8 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 6-8 weeks, then the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth.

12. Community Liability: The community where patient resides is not responsible in any way for services provided by Caring Mobile Dental, and accordingly, the community has no liability whatsoever for any claims that a patient may have against Caring Mobile Dental in connection with such services.