Online Registration: https://enabledental.com/new-patient-registration/
Email to: info@enabledental.com
Fax to: (866) 815-3719
Mail to: 5555 N Lamar Blvd, Ste H125, Austin, TX 78751
Questions? Call us at: (866) 988-4504

New Patient Consent Form

Enable Dental provides on-site mobile dentistry solutions. We provide care to our patients in various environments including in personal residences, corporations, assisted living facilities, nursing homes, and group homes. 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 ($124), x-rays ($159), and cleaning with fluoride treatment ($209). 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 Enable Dental is competitive with traditional practices and more convenient for the patient.

Initial Comprehensive Dental Examination $124

Low Dose X-rays

- FMX (Full Mouth Series) once every 3 years . . . $159
- Bitewings completed every 6 months $107

Cleaning with Fluoride Treatment $209

Cleaning without Fluoride $152

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

Exams	Exams occur every 6 months unless otherwise requested. The initial new patient exam is $124. All follow-up routine periodic exams are $96.
Low Dose X-rays	Low dose x-rays are required for all new patients, no exceptions. FMX (full mouth series) are taken once every 3 years and bitewings are taken every 6 months.
Cleanings (Prophylaxis)	A dental prophylaxis performed by a dentist or dental hygienist includes scaling and polishing to remove coronal plaque, calculus, and stains. We default to cleanings every 3 months if this field is left blank. O Every 3 months [Recommended] O Every 6 months O No cleanings
Fluoride Opt Out	☐ Check here to opt out of fluoride treatments ($57). 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.
Hygiene Therapy Program (HTP) - only for participating facility partners	COVID-19 HAS IMPACTED THIS OFFERING. SIGN UP TO GET ON THE WAITING LIST. HTP is a weekly toothbrushing, flossing, denture check, and hygiene instruction program completed by a Dental Assistant. This supplemental program is in addition to regular cleanings. O No O Yes if available ($41 per week) O Maybe - I'd like to learn more

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

The person filling out this form is the: O Patient O POA or Responsible Party Gender: O Male O Female

Patient Telephone _____ Patient Email _____

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

If patient resides in a Community/Facility:

Community/Facility Name (clarify property if multi-location brand) _____ _____

Community/Facility City _____ Room #_____

If patient resides in a Personal Residence:

Address _____ City _____ State _____ Zip _____

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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)

- ☐ 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
- ☐ Heart valve replacement
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ Any immune deficiency
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Radiation treatments (specify if head/neck)
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sickle cell anemia
- ☐ 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

Allergies

- ☐ Allergic to Aspirin
- ☐ Allergic to Penicillin
- ☐ Allergic to latex
- ☐ Allergic to sulfa drugs
- ☐ 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? ○ 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: _____

_____

Primary Care Physician / MD: _____ Contact Information: _____

DENTAL HISTORY

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

Date of the last dental exam? _____

Main concern for dental visit _____

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

Enable Dental is happy to send an out-of-network dental insurance claim on your behalf. We are an out of network provider (not in-network) on most insurance plans and you will be reimbursed directly based on your out of network benefits. Please check with us if you are uncertain about in-network or out-of-network. Any insurer payments will come from the insurer and be sent directly to the subscriber listed below. We do this as a courtesy and any follow-up communication with the insurer must be handled by the subscriber listed below.

You understand payment is due in full at the time of services and is not dependent on the reimbursement you may receive from your dental insurance plan. Reminder that HMO dental plans are strictly in-network providers only and are not viable for us to assist in sending claims and will never get reimbursement.

Group No/Name_____ Employer Name_____

Insurance Name_____ Insurance Phone #_____

Insured/Subscriber First Name_____ Insured or Subscriber Last Name_____

Insured/Subscriber Address _____ City _____ State _____ Zip _____

Insured/Subscriber Birth Date (mm/dd/yyyy)_____ Subscriber ID_____

Insured/Subscriber 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 (in some states)
- Medicare – Medicare does not cover the cost of any dental services. See https://www.medicare.gov/coverage/dental-services
- Financial information in the form of a credit card or ACH information is required
- 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 _____

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WE LIKE TO RECOGNIZE THOSE WHO RECOMMEND OUR SERVICES

How did you hear about us?

- O Online search or advertisement
- O Community/facility staff _____
- O Family or health facility event
- O An existing patient/POA of ours _____
- O Home care or home health organization _____
- O Doctor or nurse practitioner _____
- O Post card in the mail
- O Other _____

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 Enable Dental's affiliated dental practice 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. Enable Dental will not perform any restorative treatment without written approval from the patient/POA.

By signing below, you are acknowledging that:

- You are the patient and make full financial and medical decisions on your own behalf OR you are the Power of Attorney with full financial and medical legal decision-making capability.
- 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 Enable Dental 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: Please read them at https://enabledental.com/HIPAA. 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@enabledental.com, or calling (866) 988-4504. You may reach out to the Privacy Officer, Ben Tiggelaar, at ben@enabledental.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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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.

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, monthly 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.

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 reline (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. Complaints: Please contact us directly at info@enabledental.com with any complaints or issues. A manager will handle the complaint and address any issue you may have to your satisfaction. Patients in Texas can submit a formal complaint to: Texas State Board of Dental Examiners, 333 Guadalupe Tower 3, Suite 800, Austin, Texas 78701-3942 or by calling (512) 463-6400.

12. Teledentistry: If allowable in your state, you consent to utilizing synchronous (live chat via video) and asynchronous teledentistry (not live). Asynchronous teledentistry utilizes a dental assistant or dental hygienist to collect clinical data and information in-person on behalf of a licensed dentist. This information is sent asynchronously (not live) to the licensed dentist to review and provide recommendations. The results of this exam are then communicated to the patient or responsible party. The dentist may not see the patient in-person. You may request to communicate in real-time with the dentist about these findings within 30 days of the consult.

13. Clinical Services: All clinical services are rendered by a dentist owned entity including but not limited to Texas Mobile Dentists Inc (Texas), Tsang Mobile Dental PLLC (Colorado), A. Nguyen Dental Corporation (California), Scuyler Kurlbaum DDS Mobile LLC (Kansas City), Nathan Suter DDS Mobile LLC (St. Louis), and Nathan Suter DDS PLLC (Washington).

14. COVID-19: Our clinical teams follow all CDC, state dental board, and OSHA guidelines relating to COVID-19. Read our detailed guidelines at enabledental.com/covid-19. There is exists a potential risk of exposure with any human interaction given community spread. Our protocols and procedures err on the side of caution.