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 Registration and Consent

Welcome to Enable Dental. We provide portable at-home dentistry solutions in various environments including personal residences, corporate locations, assisted living communities, nursing homes, and group homes. Our clinicians provide a full range of services which include comprehensive exams, low dose radiographs, X-rays, dental cleanings, fluoride treatments, fillings, extractions, crowns, partials, dentures and much more! This Patient Consent form is designed to gather your health history as well as help you understand the options of improved quality of care that are available to you.

WHAT TO EXPECT AT YOUR VISIT

Enable Dental will perform an initial comprehensive dental examination which includes an oral cancer screening and x-rays, which are required for all new patients for the dentist to determine the patient's dental diagnosis. At this visit, the patient most likely will receive a standard cleaning. In the initial exam the dentist may identify issues which would require a personalized treatment plan and eliminate the standard cleaning. New patients are also offered an optional fluoride treatment.

ADDITIONAL FOLLOW-UP VISITS

Enable Dental's patients will receive a periodic 6-month follow-up exam, denture checks, oral cancer screening, cleaning (prophylaxis) with fluoride and x-rays which is performed by a dentist or dental hygienist unless otherwise stipulated. Additional follow-up cleanings may occur every 3 months and are based on the recommendations of the dentist. If the dental diagnosis requires additional follow-up and treatment, the dental team will provide an outline of any needed therapy (treatment plan) which will be communicated to the patient or their legal representative via email or first-class mail.

SERVICES AND PRICING

	New Patient Visit	Periodic Follow-Up Visit
• Comprehensive exam and cancer screening	$124	$96
• Low dose X-rays*	$159	$107
• Prophylaxis cleaning**	$152	$152
• Fluoride treatment	$57	$57

*Note: Denture check may need to include X-rays

**Cleaning is subject to dental diagnosis and will reduce the price by $152 if not provided

OPTIONAL SELECTIONS

☐ **I do not** wish for the patient to receive the initial fluoride treatment. I understand fluoride treatments are recommended by the American Dental Association and help prevent tooth decay.

☐ **$44 – Hygiene Therapy Program** (Available in participating communities only) 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.

WHO IS FILLING OUT THE FORM?

The person filling out this form is the: ☐ Patient ☐ POA or Responsible Party ☐ Emergency Contact ONLY

RESPONSIBLE PARTY

☐ The Patient is the responsible party and can sign for both medical and financial decisions

☐ The Patient requires a Medical Power of Attorney (POA) or Guardian, and this information is provided below; and/or

☐ The Patient requires a Financial Power of Attorney (POA) or Conservator, and this information is provided below.

Patient's Name

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PATIENT INFORMATION

The patient currently resides in a: ☐ Community/Facility ☐ Personal Residence
First Name _____ Last Name _____ Date of Birth _____ Gender: ☐ Male ☐ Female
Patient Telephone _____ Patient Email _____

EMERGENCY CONTACT INFORMATION

First Name _____ Last Name _____ Telephone _____
Relationship _____ Email _____

*IF THE PATIENT RESIDES IN A SENIOR OR ASSISTED LIVING COMMUNITY:

Community/Facility Name (clarify property if multi-location brand) _____
Address _____ Community Phone _____
Community City _____ Room #_____
☐ I am enclosing a current medication list and Face Sheet from the community

*IF THE PATIENT RESIDES AT A PERSONAL RESIDENCE:

Address _____ City _____ State _____ Zip _____

FOR PATIENTS WHO LIVE AT A PERSONAL RESIDENCE ADDITIONAL INFORMATION IS REQUIRED – PLEASE DOWNLOAD THIS FORM OR FILL OUT THE ADDITIONAL FORM ON THE ENABLE DENTAL WEBSITE: www.enabledental.com/new-patient-registration

https://enabledental.com/wp-content/uploads/2022/09/New-Patient-Dental-and-Health-History-NPDHH09162022F.pdf

MEDICAL POWER OF ATTORNEY / GUARDIAN (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 / CONSERVATOR (IF APPLICABLE)

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

DENTAL HISTORY

Does the patient wear dentures: Complete? ☐ Yes ☐ No Partial? ☐ Yes ☐ No
Date of last dental exam? _____ Main concern for dental visit _____

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DENTAL INSURANCE (AS A COUTESY WE CAN SUBMIT A CLAIM 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 may be partially reimbursed directly based on your out of network benefits. Please check with us if you are uncertain about in-network or out-of-network status. We submit claims 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.** If you have an HMO dental plan, you must use an in-network provider, and they typically do not accept out-of-network claims. We do not send claims in these situations.

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)
  - Checks are accepted for the **initial visit only**. A credit card or bank account must be stored on file for follow-up treatment
    - You may send a check to the address listed on this form prior to the initial visit **only**
    - Financial information in the form of a credit card or ACH information is required for follow-up treatment
- We **do not** accept Medicare or Medicaid in most situations
  - Medicare **does not** cover the cost of any dental services. See https://www.medicare.gov/coverage/dental-services
- A 5% late fee may be applied to any outstanding balance not paid within 30 days of services being rendered
- A home visit fee will be applied for each visit if the location of service is a personal residence (not a community).
- All fees are subject to change.

PICK ONE OF THE FOLLOWING PAYMENT OPTIONS (Required At The Time Of Service):

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 _____
Signature_____ Date _____

OPTION 2

◯ ACH (WE WILL SEND YOU A RECEIPT)

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

OPTION 3

◯ PERSONAL CHECK FOR INITIAL VISIT ONLY

A check must be presented at the first appointment. If the check needs to be mailed, please send this prior to the appointment. This can be sent into 5555 N Lamar Blvd, Ste H125, Austin, TX 78751

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AUTHORIZATION AND RELEASE

The patient or their legal representative agrees to the following:

- Enable Dental may review medical records, examine, and provide any necessary dental care;
  - Prior to signing any documents, I have the right to review the following policies of Enable Dental with which I have been provided, read and fully understood:
    - General Dental Informed Consent https://enabledental.com/general-dental-informed-consent
    - HIPAA Notice of Privacy Practices https://enabledental.com/hipaa/
    - Privacy Policy Terms and Usage* https://enabledental.com/privacy-policy/
  - No guarantee or assurance has been made as to the results that may be obtained through the course of any treatment;
  - Enable Dental is authorized to provide continued care until dental consent is withdrawn, which may be withdrawn at any time;
  - No restorative treatment will be provided without prior written consent.

* 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.

By checking and signing below, you are acknowledging that:

- You are the patient and make full financial and medical decisions on your own behalf OR you are Legal Representative with full financial and medical legal decision-making capability.
- You have read and agreed to the General Dental Informed Consent
- If applicable, you give the care community and Enable Dental explicit consent to exchange patient health information including medical history, medication lists, responsible party information and other information to ensure 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.

SIGNATURES

Patient

PATIENT Signature: _____ Date: _____

Power of Attorney

If a signature is required for a legal representative:

Name: _____

Signature: _____ Date: _____

If a signature is required for a second legal representative:
Name: _____

SIGN HERE: Signature: _____ Date: _____