Website: enabledental.com
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 (Missouri IDD Pilot Program)

Enable Dental has partnered with Missouri Coalition for Oral Health for the implementation of Teledentistry services for the IDD population. Program goals include improving oral health outcomes, providing oral health education, increasing access to dental care, and identifying and understanding community needs for at-home and portable dental services.

THE FIRST VISIT AND WHAT TO EXPECT

A new patient receives an initial comprehensive dental examination with oral cancer screening, x-rays, and cleaning with fluoride treatment. This program uses teledentistry as a pivotal part of the program. Any treatment recommendations will be communicated and 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.

WHO IS FILLING OUT THE FORM?

The person filling out this form is the: ◯ Patient ◯ POA or Responsible Party ◯ HCS/ICF Provider

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____

Zip _____ Gender: ◯ Male ◯ Female

RESPONSIBLE PARTY

◯ The patient is their own responsible party who can sign for, and give informed consent regarding medical needs
◯ The Patient requires a Medical Power of Attorney (POA) or Guardian, and this information is provided below
◯ The Patient requires a Financial Power of Attorney (POA) or Conservator, and this information is provided below.

PRIMARY RESPONSIBLE PARTY (MEDICAL DECISION MAKER/HEALTHCARE GUARDIAN)

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

Email _____ Relation to the Patient _____

MEDICAID INSURANCE INFORMATION

First Name _____ Last Name _____

Date of Birth _____ MO Health Net ID # _____

OTHER DENTAL INSURANCE

Insurance Carrier _____ Group # _____ ID# _____

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

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HCS/ICF PROVIDER INFORMATION (If Applicable)

HCS/ICF Provider Name: _____

The patient is a participant of ◯ HCS ◯ ICF

What state waiver is the individual currently enrolled in: _____

The patient currently resides in a: ◯ Group Home ◯ Personal Residence

SERVICE LOCATION AND CONTACT FOR SCHEDULING

Preferred dental service location:

◯ Day Hab / Community Center ◯ Group Home ◯ Private Residence ◯ Other _____

Service Location Address _____ City _____ State _____ Zip _____

Contact for Scheduling: First Name _____ Last Name _____

Telephone (Home) _____ (Cell) _____

Email _____ Relation to the Patient _____

FINANCIAL DISCLOSURES

Enable Dental is contracted as a dental provider to provide services for this program through Missouri Health Net (Medicaid) as a primary payor source. Recommended services and treatment covered by Missouri Health Net is determined by plan benefits. Patients may elect to accept non-covered services and treatment but will be responsible for payment.

All pricing is subject to change except situations governed by an active contractual agreement between Enable Dental and Missouri Health Net.

DENTAL HISTORY

Has the patient historically been sedated for routine dental exams and cleanings?

◯ Yes ◯ No ◯ Uncertain

Has the patient historically been sedated for needed dental treatment?

◯ Yes ◯ No ◯ Uncertain

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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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 Novocain, 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: _____

_____

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

Does the patient exhibit any uncontrolled or erratic movements? ◯ Yes ◯ No If "Yes", specify

_____ Primary Care Physician / MD: _____

Contact Information: _____

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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-2/,
        - 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.
    - 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.

Signature: _____ Date: _____