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

New Patient Registration and Consent

PATIENT INFORMATION

The patient: Currently resides in a: ◯ Community/Facility ◯ Personal Residence
Can the patient sign for both medical and financial decisions ◯ Yes ◯ No

First Name _____ Last Name _____ Date of Birth _____ Gender: ◯ Male ◯ Female

Address _____ City _____ State _____ Zip _____

Patient Telephone _____ Patient Email _____

Facility Name _____

DENTAL HISTORY AND CONCERNS

I'm enclosing a current medication list and face sheet from the community. ◯ Yes ◯ No (If No, please complete this form: https://enabledental.com/patients/medical-history)

Does the patient wear dentures: Complete? ◯ Yes ◯ No Partial? ◯ Yes ◯ No

Date of last dental exam? _____ Main concern for dental visit? _____

Dental Urgency: ☐ This is a non-life-threatening urgent dental need.
◯ Broken Tooth ◯ Broken/Lost Dentures ◯ Severe Pain/Swelling ◯ Other _____

POWER OF ATTORNEY / GUARDIAN (If applicable)

The power of attorney is required for ◯ Medical Decisions ◯ Financial Decisions ◯ Both

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

Email _____ Relation to the Patient _____

DENTAL INSURANCE

Does the patient have dental insurance? ◯ Yes ◯ No

Enable Dental collaborates with selected insurance and Medicare Advantage programs and will help to maximize your benefits whenever possible. You are responsible for payment of all non-covered services or services beyond your plan maximum. **You understand that based on your coverage, payment may be due in full at the time services are rendered.**

Insurance Name _____ Group No/Name _____

Insurance Phone _____ Subscriber ID _____

Insured/Subscriber First Name _____ Insured or Subscriber Last Name _____

Insured/Subscriber Birth Date (mm/dd/yyyy) _____ Insured/Subscriber Relation to Patient _____

Insured/Subscriber Address _____ City _____ State _____ Zip _____

PICK ONE OF THE FOLLOWING PAYMENT OPTIONS (**Required for services not covered by insurance**)

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 _____ Note: A $15.00 fee will be charged for all returned / declined ACH transactions.

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Enable Dental uses an encrypted system to keep information safe and secure. If you have any questions or would like to speak directly to a Billing Coordinator, please call (866) 988-4504, option #2. Your billing information must be received no later than two (2) business days prior to your scheduled appointment or your appointment will be rescheduled until it is received.

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 Dr. Nathan Suter, at compliance@enabledental.com.

FINANCIAL DISCLOSURES

- We accept credit cards, ACH payments, and (Care Credit in some states).
    - Financial information in the form of a credit card or ACH information is required for follow-up treatment.
- We participate with some Medicare Advantage programs, some Insurance plans and some Medicaid programs.
- Payment is required at the time of service unless otherwise specified through our insurance eligibility process.
- 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 the service is a personal residence (not a community).
- **All fees are subject to change. Initial visit fees are located at https://enabledental.com/standard-pricing/**

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 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.
- You acknowledge that Enable Dental provides all services in a portable setting.

SIGNATURES

PATIENT

Signature: _____ Date: _____

(The Patient is the responsible party and can sign for both medical and/or financial decisions)

POWER OF ATTORNEY

The Patient requires a Power of Attorney (POA) or Guardian specific to dental services performed.

Name: _____

Signature: _____ Date: _____