

# New Patient Consent Form

**KC Mobile Dental** provides on-site mobile dentistry solutions. We provide care to our patients in various environments including assisted living facilities, nursing homes, group homes, and personal residences. Our affiliated clinicians provide a full-suite of services including exams, low dose x-rays, prophylaxis cleanings, fluoride treatments, fillings, extractions, crowns, partials, dentures, and more!

## THE FIRST VISIT AND WHAT TO EXPECT

A new patient typically receives an initial comprehensive dental examination with oral cancer screening (\$100), x-rays (\$100), and cleaning with fluoride treatment (\$193). 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 KC Mobile Dental is competitive with traditional practices and more convenient for the patient.

Initial Comprehensive Dental Examination . . . .	\$100
Low Dose X-rays (4 decay disclosing x-rays) . . .	\$100
Cleaning with Fluoride Treatment. . . . .	\$193
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).

## 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>.

<b>Exams</b>	Exams occur every 6 months unless otherwise requested. The initial new patient exam is \$100.
<b>Low Dose X-rays</b>	Low dose x-rays are required for all new patients. X-rays are taken, at a minimum, every 12 months after that.
<b>Cleanings (select one)</b>	<input type="radio"/> Every 3 months [Recommended] <input type="radio"/> Every 6 months <input type="radio"/> No cleanings
<b>Fluoride</b>	<input type="checkbox"/> Check here to opt out of fluoride treatments. 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 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/Facility 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 \_\_\_\_\_

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

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

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

Primary Care Physician / MD: \_\_\_\_\_ Contact Information: \_\_\_\_\_

**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 KC 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. KC 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@kcmobiledental.com, or calling (816) 548-1270. You may reach out to the Privacy Officer, Ben Tiggelaar, at ben@kcmobiledental.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: \_\_\_\_\_

**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

☐ Insurance Claim Form: Mark here if you would like an Insurance Claim Form to be included with all of your billing statements. Please verify first that your policy covers out-of-network provider procedures. You are responsible for submitting the form, but we are here to help if you run into any issues.

**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: First Name \_\_\_\_\_ Last Name \_\_\_\_\_

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 KC 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 KC 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 KC 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 KC 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: \_\_\_\_\_

## GENERAL DENTAL INFORMED CONSENT

KC 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 psychological 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 gum tissues. The cost for this procedure 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. Complaints:** Please contact us directly at (816) 548-1270 or email info@kcmobiledental.com with any complaints or issues. Our top priority is patient and family satisfaction and we will do everything to make sure you get the best experience possible.
- 13. Community Liability:** The community where patient resides is not responsible in any way for services provided by KC Mobile Dental, and accordingly, the community has no liability whatsoever for any claims that a patient may have against KC Mobile Dental in connection with such services.