KC Mobile Dental

Phone: (816) 548-1270
Fax: (913) 267-7290
Email: info@kcmobiledental.com

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 & 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 is competitive with traditional practices and more convenient for the patient and facility.

Initial Comprehensive Dental Examination	$100	Cleaning with Fluoride Treatment	$190
Low Dose X-rays (4+ decay disclosing x-rays)	$100	Cleaning without Fluoride	$143

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

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.

Exams	Exams occur every 6 months unless otherwise requested. The initial new patient exam is $100. All follow-up routine periodic exams are $87.
Low Dose X-rays	Low dose x-rays are required for all new patients. X-rays are taken every 6 months. We have established this as a our standard of care because the senior population is at high risk of oral disease.
Cleanings (Prophylaxis) →	A dental prophylaxis performed by a dental hygienist includes scaling and/or polishing procedures to remove coronal plaque, calculus, and stains. Cleanings typically happen a few days after the exam! ○ **Every 3 months [Recommended]** ○ **Every 6 months** ○ **No cleanings**
Fluoride Opt Out	☐ Check here to opt out of fluoride treatments ($47). 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.
Hygiene Therapy Program (HTP) - only for participating facility partners →	HTP is a weekly toothbrushing, flossing, denture check, and hygiene instruction program completed by a Dental Assistant. This supplemental program (doesn't replace regular Prophylaxis Cleanings) was created at the request of families and communities to improve the patient's oral hygiene status. Patients enrolled in this program will receive 15% off all treatment (excludes exams and cleanings)! ○ **No** ○ **Yes if available ($40 per week)** ○ **Maybe - I'd like to learn more**

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 _____

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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
- ☐ Skin rash
- ☐ 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 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: _____

DENTAL HISTORY

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? _____

Main concern for dental visit (optional) _____

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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.
- 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 us 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: 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: _____

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FINANCIAL POLICY CONSENT

- Full payment is due at the time of service. There will be a 5% late fee if the bill is not paid within 30 days of services rendered.
- We accept checks, credit cards, and ACH payments, and Care Credit
- 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 otherwise you might not get reimbursed. You are responsible for submitting the form, but we are here to help if you run into any issues.

PAYMENT DISCLOSURES:

Late Payment Fee: I understand a 5% late fee for my outstanding balance will be assessed if my bill is not paid within 30 days of services being rendered.

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 us to process the above credit card. 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.

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.

SIGN HERE ➔ Signature: _____ Date: _____

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 _____

OPTION 3

SEND ME A BILL

Send me a bill. There will be a 5% late fee if your bill is not paid within 30 days of services rendered date:

O Email _____

O Mail: First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Note: Backup financial information in the form of credit card of ACH is required for treatment greater than $500.

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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. 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 every 6 months for geriatric patients who are at high risk of oral disease.

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. In rare circumstances these needs may break off and be lodged in soft tissue.

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 usually 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. No refunds/cancellations are possible after the case has been sent to the lab for final processing.

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. Periodontal Loss (Tissue & Bone): This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth.

12. Complaints: Please contact us directly at (816) 548-1270 or email info@kcmobiledental.com with any complaints or issues.

13. Community Liability: The community where patient resides is not responsible in any way for services provided by us, and accordingly, the community has no liability whatsoever for any claims that a patient may have against us in connection with such services.