Houston (713) 347-6833
Dallas (214) 550-7323

MOBILE DENTAL ASSOCIATES

Info@mobiledentalassociates.com
FAX-(713) 347-6844

NEW PATIENT REGISTRATION

Welcome to Mobile Dental Associates! We are excited to have you/your loved one join our family of patients! The following information is needed to be able to provide the quality of care you should expect and deserve from a Mobile Dental Team. Please be as thorough as possible and if you have any questions feel free to call us or send us an email. We are happy to help!

How did you hear about us? Google Facebook X(Twitter) Instagram Insurance Person_____ Agency_____

PATIENT INFORMATION

Where Does The Patient Currently Reside? (Please check only one)

☐ Private Residence ☐ Senior Living ☐ Assisted Living ☐ Independent Living ☐ Memory Care ☐ Skilled Nursing ☐ Group Home

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

_____ _____ **Marital Status:** ☐ Married ☐ Widowed ☐ Single **Gender:** ☐ M ☐ F
Name of Patient's Community...(If Applicable) Patient's Room #

Address: _____

City: _____ **State:**_____ **Zip Code:** _____

Patient Cell Phone #:(____) _____ - _____ **Patient Email:** _____

Emergency/Alternate Contact Name:_____ **Cell Phone #:(____) _____ - _____**

INFORMATION ABOUT THE PERSON WHO IS COMPLETING THIS FORM (IF NOT THE PATIENT)

Name:_____ _____ _____
First Last DOB

Street Address:_____

City:_____ State:_____ Zip Code:_____

Cell Phone #:(_____) _____ - _____ Email:_____

SIGNATURE

_____ _____ _____
Signature (If other than patient) (Please Print Signer's Name) Date

Signer/Responsible Party Legal Authority? ☐ Patient(self) ☐ Guardian ☐ Power of Attorney ☐ Conservator ☐ _____

Signer/Responsible Party Relationship To Patient? ☐ Patient(self) ☐ Daughter ☐ Son ☐ Spouse ☐ Parent ☐ _____

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MEDICAL & DENTAL INFORMATION

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

Question	Yes	No	Please explain "Yes" answers.
Is the patient currently being treated for any symptom or condition?	☐	☐	
Is the patient currently taking blood thinners?	☐	☐	
Has the patient taken Fosamax, Boniva, Actonel or other Bisphosphonates?	☐	☐	
Has the patient been experiencing unusual weight loss?	☐	☐	

Allergies and Medical Symptoms and Conditions (Please check all that apply)

Patient is Allergic To:		Symptoms & Conditions		Symptoms & Conditions		Symptoms & Conditions	
☐	NO KNOWN ALLERGIES	☐	Anorexia	☐	Fainting Spells	☐	Nervous System Disorder
☐	Amoxicillin	☐	Arteriosclerosis	☐	Fever Blisters	☐	Pacemaker
☐	Erythromycin	☐	Arthritis	☐	Frequent Headaches	☐	Premedication Required
☐	Penicillin	☐	Asthma	☐	Frequent Dry Mouth/Sjogren	☐	Radiation Therapy
☐	Other Antibiotics	☐	Autoimmune Disease	☐	Gag Reflex	☐	Rheumatic Fever
☐	Barbiturates / Sleeping Pills	☐	Blood Clotting Problems	☐	Gall Bladder Trouble	☐	Rheumatic Heart Disease
☐	Codeine	☐	Blood Transfusion	☐	Heart Attack	☐	Rheumatoid Arthritis
☐	Other Narcotics	☐	Bronchitis	☐	Heart Disease	☐	Seizures
☐	Epinephrine	☐	Bulimia	☐	Heart Murmur	☐	Sexually Transmitted Disease
☐	Other Local Anesthetics	☐	Cancer/Tumor or Growth	☐	Hepatitis	☐	Shortness of Breath
☐	Iodine	☐	Cardiovascular Disease	☐	Herpes	☐	Sickle Cell Anemia
☐	Latex Rubber	☐	Chemotherapy	☐	High Blood Pressure	☐	Sinusitis
☐	Sulfa Drugs	☐	Chest Pain (upon exertion)	☐	Hives	☐	Skeletal Disease/Disorder
Please list other known allergies below:		☐	Congenital Heart Defect	☐	Jaundice	☐	Skin Rash
Symptoms and Conditions ↓ ↓ ↓		☐	Congestive Heart Failure	☐	Joint Replacement	☐	Stomach Ulcers
		☐	Damaged Heart Valve	☐	Kidney	☐	Stroke
☐	AIDS/HIV infection	☐	Dementia	☐	Leukemia	☐	Thyroid
☐	Abnormal Bleeding	☐	Diabetes	☐	Liver Disease	☐	Tuberculosis
☐	Alzheimer's Disease	☐	Diarrhea (Persistent)	☐	Low Blood Pressure	☐	Urinary Tract Infections
☐	Anemia	☐	Emphysema	☐	Lupus	☐	Urinates Frequently
☐	Angina	☐	Environmental Allergies	☐	Mental Health Problems	☐	Other conditions not listed?
☐	Ankles Swell	☐	Epilepsy	☐	Mitral-Valve Prolapse	Approx. Weight_____ Height_____	
Other Allergies:							

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

PHYSICIAN INFORMATION

PCP (Primary Care Physician)	NAME	CONTACT PHONE #

PRESCRIPTIONS

	DRUG NAME	DOSAGE PER DAY		DRUG NAME	DOSAGE PER DAY
1			6		
2			7		
3			8		
4			9		
5			10		

If additional space is needed, please email additional medication list to info@mobiledentalassociates.com.

DENTAL INFORMATION

DENTAL QUESTIONAIRE	
WHAT IS THE PRIMARY REASON FOR CONTACTING THE DENTIST? (Please be as detailed as possible)	
When was the patient last seen by a dentist? ☐ <12 Mo's ☐ >12 Mo's	Is the patient having difficulty eating? ☐Yes ☐No
How often does the patient brush their teeth? ___Times Per_____	Do the patient's gums bleed? ☐Yes ☐No
Is the patient cooperative during dental treatment? ☐Yes ☐No	Does the patient have dentures? ☐Yes ☐No
Has the patient ever had a reaction to anesthetic? ☐Yes ☐No *If Yes...please describe:*	Has the patient ever had to be sedated for dental treatment? ☐Yes ☐No

SIGNATURE ACKNOWLEDGEMENT

My signature below authorizes the release of any and all healthcare records for the above-named patient. I also attest that, to the best of my knowledge, that I have provided the most accurate medical & dental information related to the above-named patient and that the dentist will rely on this information for treatment decisions and therefore release the treating dentist from any responsibility that may arise related to any omissions or inaccuracies of information provided.

_____ _____ _____
Signature Please Print Signer's Name Date

Signer/Responsible Party Legal Authority? ☐Patient(self) ☐Guardian ☐Power of Attorney ☐Conservator ☐_____

Signer/Responsible Party Relationship To Patient? ☐Patient(self) ☐Daughter ☐Son ☐Spouse ☐Parent ☐_____

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OFFICE POLICIES & FINANCIAL RESPONSIBILITY

Patient Name: _____ ____ _____ _____ _____
First M.I. Last Nickname DOB

PAYMENT FOR SERVICES

Payment for all services provided by Mobile Dental Associates is expected at the time of service from the patient or the patient's responsible Party unless other arrangements have been mutually agreed to beforehand. Regardless of the payment type, a credit/debit card will be kept on file for payment security. We accept checks, debit cards, HCS Acct Cards, and all traditional major credit cards(Visa, Mastercard, American Express, Discover), Care Credit, and payments through the Zelle banking app. There will be a 3.00% additional convenience fee for paying with a traditional Credit Card. Charges for services are due and payable at the time the services is provided. If the service is a multi-visit procedure (Ex: Crown, Bridge, Denture) the full charge is due when the procedure begins . If a patient's health situation declines such that it prevents the completion of a multi-visit procedure the amount of the charge will be reasonably prorated for the portion of services that were completed and the expenses incurred up to the date treatment ceases. If there is a remaining unpaid prorated amount, that amount will be due by the patient or patient's representative. Alternatively, if there is a credit on the account in excess of the prorated charges, a partial refund will be issued.

REQUIRED SECURITY PAYMENT INFO

Credit Card #		CVV Code		Exp. Date	
Card Type?:	☐ Visa ☐ Mastercard ☐ American Express ☐ Discover				

Name as it appears on the credit card to be billed:					
Billing Address:					
City:		State:		Zip Code	

DENTAL INSURANCE

So long as accurate Insurance information is provided below, we will file a patient's claim(s) for the services we provide as a courtesy. The first visit must be paid in full by the patient or patient's responsible party. Our practice participates with a limited number of traditional, PPO and Medicare advantage plans. depending on the patient's in & out-of-network benefits, the insurance company **may** partially reimburse the patient for the services that they choose to cover based on the policy Mobile Dental Associate doctors are typically OUT-OF-NETWORK providers with most insurance companies with a few exceptions, but most policies with out-of-network benefits (except HMOs, Medicaid and Medicare) provide some sort of coverage for our services. In some cases, Medicaid will provide limited benefits that are preauthorized and approved. There are some Medicare Advantage Plans that offer limited Dental Benefits. We attempt to help the patient maximize their benefits in good faith but ultimately the patient is responsible for payment of all charges for services provided regardless of expected or actual insurance coverage.

INSURANCE INFO:
This information can typically be found on the insured wallet card

Does The Patient Have Primary Dental Insurance? ☐ Yes (If "Yes" please complete below) ☐ No (If "No" please leave info blank and sign below)

Name of Ins. Co.		**Ins. Co. Phone #**	
Insured's Name		**Relationship to Patient?**	
Group Number		**Insured's SSN or ID**	

Please forward a front and back copy/picture of the patient's Insurance Wallet Card to: Info@mobiledentalassociates.com.

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OFFICE POLICIES & FINANCIAL RESPONSIBILITY
Continued...

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

Consent to Electronic Communications Via Email and Text

Unencrypted email and texts are not a secure form of communication. There is some risk that any individually identifiable health information and or other sensitive or confidential information may be misdirected, disclosed to, or intercepted by unauthorized third parties. Your signature below consents to the use of email and SMS text communications regarding your dental care. Examples of such communications are, but not limited to appointment reminders, appointment confirmations, patient satisfaction surveys, financial transactions (receipts for payment, statements, account history reports, etc.), periodic announcements, discounts, specials, seasonal promotions etc.

MISSED/CANCELLATION/NO-SHOW POLICY (24 HOUR NOTICE REQUIRED)

When our office schedules an appointment, we set aside and dedicate our chair time, materials, team labor and travel time just for the patient. We simply ask that if the patient must reschedule the appointment, that we are provided at least 24 hours' notice. This courtesy makes it possible for us to offer the reserved time to another patient. There is a minimum charge of $75.00 and $75.00 per additional hour for failing or canceling appointments with less than 24hrs notice. *Repeated cancellations or missed appointments will result in loss of future appointment privileges. We appreciate your cooperation and understanding.

Consent to Photography

I authorize and consent to the use of photographs/x-rays of me taken by Mobile Dental Associates. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the mobile practice of dentistry. I consent to the use of my photographs or images for marketing materials including website and patient education for Mobile Dental Associates only. I further understand that if the photographs and/or images are used, my name or similar identifying information will **not** be used. I specifically waive any claim for invasion of my personal privacy in connection with such photographs/x-rays. Any full face or comparable photos will be altered to conceal my identity with the use of sunglasses or black bard blocking the areas of my eyes. Lastly, I acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

Your signature below indicates your acknowledgement, consent and agreement with our Payment Policy, Missed Appointment Policy, Insurance Claims Policy, Electronic Communications Policy and Photography Consent above. Your consent To Electronic Communications can be modified or retracted at any time by notifying us in writing or by email to: contact@mobiledentalassociates.com.

_____ _____ _____
Signature **Please Print Signer's Name** **Date**

Signer/Responsible Party Legal Authority? ☐Patient(self) ☐Guardian ☐Power of Attorney ☐Conservator ☐_____

Signer/Responsible Party Relationship To Patient? ☐Patient(self) ☐Daughter ☐Son ☐Spouse ☐Parent ☐_____

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CONSENT FOR FIRST DENTAL VISIT

Patient Name: _____ _____ _____ _____

First M.I. Last Nickname DOB

FIRST VISIT

IN-PERSON EXAMINATIONS AND X-RAYS I understand that the initial visit will likely require radiographs(X-Rays), intra-oral photographs, and in some cases digital scans in order to complete the examination, diagnosis and treatment plan. I understand and consent to these diagnostic services to be performed on the initial visit and subsequent visits as deemed appropriate by the Dentist.

TELEDENTISTRY EXAMINATION AND X-RAYS: When necessary, and requested by the patient or patient's representative, we may provide and initial asynchronous Teledentistry visit (not live). Asynchronous Teledentistry is where clinical data is collected by a dental assistant or dental hygienist in-person on behalf of a licensed dentist. This information is sent electronically to the dentist at another location to review and provide an initial recommendation(s). The results of the dentist's exam are then discussed with the patient or responsible party and in-person treatment with the dentist or hygienist will be scheduled at another time.

TYPES OF CLEANINGS ON FIRST VIIST

After the examination and based on the patient's condition(s) at that time, the patient will receive one of the following 3 types of cleanings on their first visit as recommended by the dentist.

1) **DENTAL PROPHYLAXIS (Routine Cleaning)** I understand that this treatment is preventative in nature and is intended for patients with healthy gums and is limited to the removal of plaque and calculus from the tooth structures above the gum line and in the absence of periodontal (gum) disease.

2) **PERIODONTAL CLEANING (Therapeutic in the presence of Periodontal Disease)** I understand that I have Periodontal disease and that a routine cleaning will not adequately treat my condition. Local anesthetic will likely be necessary to make me comfortable while the dentist/hygienist attempts to go remove bacteria, calculus, plaque buildup beneath the gums on the root surfaces of my teeth. Further treatment will be needed to adequately address my disease

3) **GROSS DEBRIDEMENT (To enable a diagnosis)** I understand that due to the amount of heavy build-up of debris and stain on my teeth, that the dentist will need to first remove this in order to even make a diagnosis. Further treatment will be needed to adequately address my disease.

FLUORIDE VARNISH Fluoride application is an important part of comprehensive preventative dentistry. Fluoride not only helps prevent new decay from developing, it also helps protect existing dental work so that fillings are replaced less frequently, decreases sensitivity, helps teeth last longer and saves you money! Fluoride is most effective when applied after the dental cleaning and all the plaque and build up have been removed from the tooth's surface.

GENERAL RISK FOR ALL DENTAL TREATMENT

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

CONSENT & ACKNOWLEDGEMENT: I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and therefore is individually responsible for the dental care rendered to me. I also understand that no other dentist or business entity, will be held responsible for dental treatment.

_____ _____ _____

Signature **Please Print Signer's Name** **Date**

Signer/Responsible Party Legal Authority? ☐Patient(self) ☐Guardian ☐Power of Attorney ☐Conservator ☐_____

Signer/Responsible Party Relationship To Patient? ☐Patient(self) ☐Daughter ☐Son ☐Spouse ☐Parent ☐_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. For example, teeth cleaning.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, sending your bill for your visit to your insurance company for payment.

Healthcare Operations: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

You can exercise any of these rights by presenting a written request to the Privacy Officer by mail to our business address as follows: **1880 S. Dairy Ashford Rd. Suite 207-413 Houston, TX 77077** or via email to HIPAA@mobiledentalassociates.com.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with a member of our staff.

Your signature below is an acknowledgement that you have reviewed our **Notice of Privacy Practices** and can access it electronically and or print a copy of it at any time on our website at: www.mobiledentalassociates.com. Your signature also consents to the use and disclosure of your personal health information by your dental office for treatment, appointments, billing/payment, and healthcare operations as outlined in this **HIPAA Notice of Privacy Practices**.

_____	_____	_____
Signature	**Please Print Signer's Name**	**Date**

Signer/Responsible Party Legal Authority? ☐ Patient(self) ☐ Guardian ☐ Power of Attorney ☐ Conservator ☐ _____

Signer/Responsible Party Relationship To Patient? ☐ Patient(self) ☐ Daughter ☐ Son ☐ Spouse ☐ Parent ☐ _____