Dragonfly Dental, LLC

2023

Dayhab / Home / Group Home / Independent / Assisted Living / Memory Care

***NEW SERVICE*…To begin dental service with Dragonfly Dental, please complete this packet and return it to us. Once we received the completed packet, we can schedule your individual dental appointment and provide service where you live.**

***PAYMENT*…Same day payment is expected at time of service. We accept Checks, Credit Cards and Debit Cards Also Clients with HCS, CLASS, DBMD & TxHmL**

Traditional Medicare does not pay for dental care. Medicare Advantage Plans offer some dental benefits but only pay a fraction of dental charges. We DO NOT accept any Dental Plan. We will bill your dental insurance plan on a NON-Assigned Basis. This means that any payment from your insurance will be paid directly to you. You are responsible for payment at time of service. An initial dental examination is $96 and includes digital x-rays. A cleaning is $125. The doctor will examine and determine treatment needed. Dental treatments must be approved by YOU or your MPOA before moving forward. The MPOA does not need to be present at any visit. Dragonfly Dental will reach out to the MPOA to discuss the treatment provided and additional treatment needed the day after your dental care. We need approval for each visit and treatment provided.

***PARKING*…Our Mobile Unit consists of a Truck with 20ft Exam Room attached. We need to park on a semi level surface and do not back up. Please allow us room to park the day of your appointment.**

COMPLETE THIS PACKET AND MAIL, E-MAIL, FAX, or CALL FOR PICKUP

Phone 214-674-2635 Fax 469-283-2931
E-Mail DragonflyDental@yahoo.com
Mail 1818 Frosted Hill Drive, Carrollton, TX 75010

If you need help completing this paperwork, please contact our office and we will be happy to assist you.

PATIENT REGISTRATION

Texas Mobile Dental License # M-24472

Today's Date:
Last Name First MI
Address Apt. #
City State Zip
Phone #
At Home: ____ or Community Name:
Birthdate Social Security Number M___ F___ _____/_____/_____ _____/_____/_____ **Social Security Number is Required to Bill You Insurance**
Who told you about Dragonfly Dental?
Circle How You Move Walk Walker Wheelchair Geri Chair Scooter Bed Bound
CURRENT PHYSICIAN Name: Phone Number:
MPOA APPOINTMENT PREFERENCE Do you need to attend dental appointments? **____Yes** **____No**

FINANCIAL RESPONSIBILITY

___PATIENT **___MPOA** **___HCS, CLASS, DBMD, TxHmL**

MEDICAL POWER OF ATTORNEY

MPOA Name:_____ _____ (Print Please)

MPOA E-Mail:_____@_____ (Print Please)

MPOA Phone: _____

(MPOA does not need to be present for appointments. We do need the MPOA to be available by phone or E-Mail after each visit so we can call and update you on the visit and review your loved ones treatment plan so you can make an informed decision)

Please provide payment information below. We bill dental insurance free for you. We do not accept payments from them. Your insurance will pay you directly instead of Dragonfly Dental.
We accept checks, credit cards and debit cards **Medicaid Providers will be Billed**

TWO PAYMENT OPTIONS (Insurance is Not a Payment Option)

____CREDIT CARD / DEBIT CARD

Name on Card _____Billing Zip Code_____

Card Number _____Expiration Date ____ / _____ CRV_____
MM YY

____CHECK (We Can Bill You)

MEDICAL HISTORY

Indicate which of the following you have had or have at present time:

Circle "YES" or "NO" to each

Heart(Surgery, Disease,Attack)..	**Yes No**	Ulcers…>……..	**Yes No**	Hepatitis A B C (circle)	**Yes No**
Congenital Heart Disease……..	**Yes No**	Diabetes…….	**Yes No**	H.I.V. Positive……	**Yes No**
Heart Murmur……	**Yes No**	Thyroid Problems…	**Yes No**	A.I.D.S……..	**Yes No**
High Blood Pressure……..	**Yes No**	Glaucoma……	**Yes No**	Cold Sores……..	**Yes No**
Mitral Valve Prolapse……	**Yes No**	Tobacco-smoke/dip.	**Yes No**	Blood Transfusion……..	**Yes No**
Artificial Heart Valve……	**Yes No**	Emphysema…….	**Yes No**	Hemophilia…….	**Yes No**
Heart Pacemaker……	**Yes No**	Tuberculosis……	**Yes No**	Sickle Cell Disease…….	**Yes No**
Rheumatic Fever……	**Yes No**	Asthma……	**Yes No**	Liver Disease……..	**Yes No**
Arthritis/Rheumatism……	**Yes No**	Blood Thinners…...	**Yes No**	Yellow Jaundice…….	**Yes No**
Cortisone Medicine..……	**Yes No**	Latex Sensitivity….	**Yes No**	Neurological Disorders..	**Yes No**
Fen Phen……	**Yes No**	Allergies/Hives……	**Yes No**	Epilepsy or Seizures…..	**Yes No**
Stroke……	**Yes No**	Tumors……...	**Yes No**	Fainting/Dizzy Spells…	**Yes No**
Artificial Joints(hip,knee,etc.)…	**Yes No**	Radiation/Chemo…	**Yes No**	Nervous/Anxious……	**Yes No**
Kidney Trouble……..	**Yes No**	Psychiatric/Psychological care…….			**Yes No**

Bisphophonates (fosamax/boniva) **Yes No** If yes how long_____ Oral/ IV

Do you have any drug allergies or reaction to any medication or substance? ___Yes ___No

If yes please describe reaction and list drug_____

Do you wear removable Dentures or Partials ___No ___Yes Denture Partial

Are you having any specific Dental Issues?_____

Recent Hospitalization History

Details (Surgery / Treatments)

Mental Health History

Diagnosis / Medications

Current Medication List (If you have a copy from the community records please attach)

MEDICATION	PRESCRIBING PHYSICIAN

DENTISTRY INFORMED CONSENT

TREATMENT, DRUGS, & MEDICATION

I understand that I am to have dental work done. I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/ or analgesic shock (severe allergic reaction). I have informed the dentist of any known allergies to medication. Women are advised that antibiotics may interfere with the effectiveness of birth control pills. Other means of contraception are recommended while taking antibiotics.

CHANGES IN TREATMENT PLAN(S)

I understand that it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination. I give my permission to Dragonfly Curb Side Dental dentists to make any, and/or all changes and additions as necessary.

CROWNS AND VENEERS

Treatment involves covering tooth completely with a cap (crown) or covering the front surface of the tooth with a colored bonded porcelain laminate called a veneer. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown, which come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will additional charges for remakes or other treatment due to my delaying permanent cementation.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally the canal filling material may extend through the root tip, which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Root fractures that are hard to detect are one of the main reasons that cause root canals to fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. It also prevents a root canal from becoming infected again. I understand that endodontic files and reamers are very fine instruments and stresses in their manufacture can cause them to separate during use. I understand that occasionally referral to a root canal specialist (Endodontist) may be necessary to re-treat difficult root canals or perform additional surgical procedures that may be necessary following root canal therapy (apicoectomy). Specialty fees are the patient's responsibility. I understand that the tooth may be lost in spite of all efforts to save it.

PERIODONTAL LOSS / SCALING & ROOT PLANNING (TISSUE AND BONE LOSS)

I understand that I have a serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restorative work.

FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. I understand that sensitivity is common after a newly place filling.

DENTURES/COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (Including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the denture fee. I understand that is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

EXTRACTIONS

No guarantee has been given to me that removing teeth will be successful to my complete satisfaction and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are:

1. Postoperative discomfort and swelling
2. Excessive bleeding
3. Damage to adjacent teeth
4. Postoperative infection requiring additional treatment
5. Stretching of corners of the mouth with resultant cracking and bruising
6. Restricted mouth opening for several days or weeks
7. Breakage of the jaw
8. Decision to leave a small piece of the root in the jaw when removing it would require extensive surgery
9. Numbness or tingling of the lip, chin, gums, cheek teeth and tongue on the extraction side. This may persist for days weeks, months or in some rare instances, permanently
10. Opening of the sinus probably requiring additional surgery

I understand I may need further treatment by a specialist if complications arise, the cost of which is my responsibility

MEMORY CARE or SPECIAL NEEDS DENTISTRY

I understand the following procedures are routinely used in conjunction with memory care and special needs dentistry, as well as being accepted procedures in the dental profession. As the authorized caregiver, I understand and give consent that the following procedures can be used:

A. POSITIVE REINFORCEMENT- Rewarding the patient who portrays desirable behavior, by use of compliments, verbal praises, or toys.

B. VOICE CONTROL- The attention of a disruptive patient is gained by changing the tone or increasing the volume of the doctor's voice.

C. DO NO HARM- As the authorized caregiver, I have been informed in advance and have given consent as it may be deemed necessary to limit the patient's disruptive movements by holding down their hands or arms with minimal force. The dentists or assistant's hand can leave Bruising on older adults.

D. SEDATION- It may be necessary to have the Primary Care Physician order a sedative before any dental examination and procedures is started. I understand that this may be necessary each time the patient needs dental treatments including cleaning. I understand that with the use of local anesthetic for dental purposes, the possibility exists that the patient may inadvertently bite their lip, tongue, and cheek causing injury to occur. If patient becomes angry, agitated or a physical threat, treatment of the patient will be stopped. At that time it will be necessary for their primary care provider to prescribe a sedative for a dental appointment re-scheduled at a later date. You may be billed for partial services performed depending on the treatments that were accomplished.

E. ORAL SEDATION FOR SPECIAL NEEDS ONLY: Some patients require ORAL sedation prior to dental treatment. The PCP for this patient must evaluate for medical fitness and cardiovascular and respiratory function prior to prescription of any sedation or anxiolytic medications. I understand that this type of sedation carries a higher risk of complications including stroke or death. You may ask for our Sedation Protocol prior to sedation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested or authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I acknowledge that I have viewed a copy of Notice of Privacy Practices @ www.DragonflyDental.com A paper copy is available if requested. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

SIGN HERE

Patient/MPOA Signature:_____Date:____/____/_____

We are governed by the State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800

Austin, TX 78701 512-463-6400

We follow HIPAA guidelines so your health information is protected with or without the HIPAA disclosure signed or not.

Authorization Form for Disclosure of Protected Health Information to Third Parties

HIPAA COMPLIANCE OFFICER; Cliff Masters DragonflyDental@yahoo.com

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

This form, if signed, will authorize the Dentist and Staff, to disclose specified dental information about the person named in Item 1 below to person(s) in Item 2 specific information in Item 3 only, If any information requested that is not listed in Item 3 to persons(s) in Item 2 WILL NOT be released without written authorization by the patient or MPOA (Medical Power of Attorney) in Item 1.

Item 1
Patient Name:_____DOB:_____ Patient Phone Number:_____

Item 2
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

Item 3
___Payments ___X-Rays ___Appointment Time and Dates
___Claim Info ___Patient Info ___Treatment Records
___Diagnosis Info ___Financial Info ___Other:_____ ___

If you sign this authorization, you can choose to revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked via e-mail to DragonflyDental@yahoo.com Attn: Cliff Masters HIPAA Compliance Officer

SIGN HERE (Optional)

Patient Signature:_____ Date:_____

OR

MPOA Signature:_____ Date:_____
(Medical Power of Attorney)