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Our dental practice is focused on providing mobile dental care where ever you live. We accept checks, credit cards, and debit cards for payment. If you have dental insurance, we will bill your insurance. Dental insurance will not pay 100% of your bill. This means you will be responsible for paying your dental bill when services are rendered with a check or credit card

You or Your MPOA (Medical Power of Attorney) please complete and sign the following paperwork before we can schedule your first visit. All information is secured and protected under federal HIPAA regulations. With out dental insurance payment for treatment is expected at the time of each visit.

**Exam is \$96, Cleaning is \$125. Additional treatment is at an additional charge. NOTE: Medicare and Medicaid DOES NOT cover dental care.**

An initial dental examination with a full set of digital x-rays is performed on the first visit. The doctor will examine and discuss what they find. If a cleaning is appropriate, the doctor can perform this during your first visit too. Additional 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. We will get approval for each visit and treatment provided.

**TO START SERVICE...**

**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](mailto:DragonflyDental@yahoo.com)

Mail      2775 Villa Creek Drive, Suite B-190   Farmers Branch, TX   75234

**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

**Patient**

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 Required Only for Insurance Billing		
Who told you about Dragonfly Dental?		
Are you able to ambulate to the treatment room? Y__ N__ Walk __ Walker __ Wheelchair__ Are you bed bound? Y__ N__ <b>At this time we are unable to provide care for Bed Bound Customers</b>		
<b>CURRENT PHYSICIAN</b>		
Name:		Phone Number:

**FINANCIAL RESPONSIBILITY**

\_\_\_\_\_ PATIENT IS FINANCIALLY RESPONSIBLE PARTY **OR**

\_\_\_\_\_ MEDICAL POWER OF ATTORNEY IS FINANCIALLY RESPONSIBLE PARTY (MPOA)

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 and accept checks or credit / debit cards.

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## PAYMENT OPTIONS **REQUIRED**

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**CREDIT CARD or DEBIT CARD**

Name on Card \_\_\_\_\_

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_  
MM YY

Security Code on Back of Card \_\_\_\_\_

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**CHECK** Checks are due at time of each exam or treatment.

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If you have dental insurance, please provide a copy of the front and back of the card. Dental Insurance will not pay 100% of your bill. Please select one of the payment options above to cover your out of pocket charges.

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## MEDICAL HISTORY

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

**Circle "YES" or "NO" to each item**

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
Bisphosphonates (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\_\_\_\_\_

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**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 relines 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 DENTISTRY**

I understand the following procedures are routinely used in conjunction with memory care 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.

**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.**

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**I acknowledge that I have viewed a copy of Notice of Privacy Practices @ [www.DragonflyDental.com](http://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

## **HIPAA FORM IS OPTIONAL BELOW**

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

# HIPAA

## Authorization Form for Disclosure of Protected Health Information to Third Parties

HIPAA COMPLIANCE OFFICER; Cliff Masters [DragonflyDental@yahoo.com](mailto: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: \_\_\_\_\_  All of  
the above  
 Expiration Date: \_\_\_\_\_

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](mailto:DragonflyDental@yahoo.com) Attn: Cliff Masters HIPAA Compliance Officer

**SIGN HERE (Optional)**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

MPOA Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Medical Power of Attorney)