

# Horseshoe Dental LLC

horseshoedental.com

164 Country Club Circle | Suite A • Minden, LA 71055

horseshoedental@gmail.com

(318)639-9559

## Welcome to our Practice

**Chart#:** \_\_\_\_\_

FOR OFFICE USE ONLY

**Patient Name:** \_\_\_\_\_  
Last First MI Preferred Name

**Title:** \_\_\_\_\_ **Gender:**  Male  Female **Family Status:**  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

**Birth Date:** \_\_\_\_\_

**SS#:** - -

**Prev. Visit:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Best time to call:** \_\_\_\_\_

**Phone:** \_\_\_\_\_  
Home Mobile Work Ext Fax Other

**Address:** \_\_\_\_\_  
Address 1 Address 2

\_\_\_\_\_  
City State Zip Code

**Primary language spoken** \_\_\_\_\_

Whom may we thank for referring you to our practice?

\_\_\_\_\_

**In an emergency who should be notified? Please enter Name and Phone number below:**

\_\_\_\_\_

\_\_\_\_\_



**Primary Dental Insurance:**

**Name of Insured:** \_\_\_\_\_  
Last First MI

**Insured's Birth Date:** \_\_\_\_\_

**ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insured's Address:** \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

**Insured's Employer Name:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

**Patient's relationship to insured:**  Self  Spouse  Child  Other

**Insurance Plan Name:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Insurance Authorization:

By checking this box,  
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.  
I authorize the use of this electronic signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure the payment of benefits.  
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature \_\_\_\_\_ **Date** \_\_\_\_\_

## Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> *Pre-Med - Amox   | <input type="checkbox"/> *Pre-Med - Clind    | <input type="checkbox"/> *Pre-Med - Other     | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine   | <input type="checkbox"/> Allergy - Erythro    | <input type="checkbox"/> Allergy - Hay Fever  |
| <input type="checkbox"/> Allergy - Latex   | <input type="checkbox"/> Allergy - Other     | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa      |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> blue dye            | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Codeine              |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Dizziness/Fainting  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Excessive Bleeding   |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur         |
| <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Jaundice             |
| <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Latex               | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Mental Disorders     |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> other               | <input type="checkbox"/> OTHER                | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> PCN allergy       | <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Rheumatism          | <input type="checkbox"/> sea food             | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Stomach Problems  | <input type="checkbox"/> Stroke              | <input type="checkbox"/> sulfa                | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Tumors            | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Venereal Disease     |   |

- |   |  |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury)         | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements                      |
| <input type="checkbox"/> Subject to frequent headaches                      | <input type="checkbox"/> A smoker or smoked previously                   |
| <input type="checkbox"/> FEMALE: Taking birth control pills                 | <input type="checkbox"/> FEMALE: Pregnant                                |

**If any condition or alert selected above needs further clarification, please explain below:**

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**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

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**Do you take a blood thinner?**  Yes  No

**Please list ALL allergies:**

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**What is your estimate of your general health?**

Excellent  Good  Fair  Poor

**Name of physician and their specialty:**

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**Most recent physical exam and purpose:**

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**Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:**

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**List all medications, supplements, and/or vitamins currently taken:**

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**Name and phone number of preferred pharmacy:**

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\* **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

## Dental Information

**How would you rate the condition of your mouth?**

- Excellent  Good  Fair  Poor

**Previous Dentist name and how long you have been a patient there:**

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**Date of most recent dental exam:** \_\_\_\_\_

**I routinely see my dentist every:**

- 3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

**What is your immediate concern?**

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**Please check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Had complications from past dental treatment     | <input type="checkbox"/> Had trouble getting numb                      |
| <input type="checkbox"/> Had any reactions to local anesthetic            | <input type="checkbox"/> Had/Have braces or orthodontic treatment      |
| <input type="checkbox"/> Experiences dry mouth                            | <input type="checkbox"/> Sensitive to hot, cold, biting, sweets        |
| <input type="checkbox"/> Avoid brushing any part of your mouth            | <input type="checkbox"/> Food gets trapped between any teeth           |
| <input type="checkbox"/> Whitened or bleached your teeth                  | <input type="checkbox"/> Experienced popping / clicking of jaw joint   |
| <input type="checkbox"/> Difficulty chewing                               | <input type="checkbox"/> Clenching or grinding of teeth                |
| <input type="checkbox"/> Currently or previously wore a bite appliance    | <input type="checkbox"/> Gums bleed when brushing or flossing          |
| <input type="checkbox"/> Diagnosed and/or treated for gum disease         | <input type="checkbox"/> Bone loss around your teeth                   |
| <input type="checkbox"/> Noticed an unpleasant taste / odor in your mouth | <input type="checkbox"/> Experienced gum recession                     |
| <input type="checkbox"/> Teeth become loose on their own (without injury) | <input type="checkbox"/> Experienced a burning sensation in your mouth |
| <input type="checkbox"/> Snores or wakes up frequently during the night   |  |

## Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the insurance company and that he or she is personally responsible for all patient portions of dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. \*If insurance is terminated, and services are rendered, then it is the patients responsibility for cash price payment of services. A service charge of 10% on accounts exceeding 60 days. I understand that after 90 days, my account will be turned over to collections.

I understand that any fee estimate for this dental care can only be extended for a period of 30 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HORSESHOE DENTAL PATIENT POLICIES:  
BE SURE TO READ BEFORE SIGNING**

**APPOINTMENT CONFIRMATION:**

Our office will contact you on the day before your scheduled appointment to confirm your appointment. We **MUST** receive a confirmation from you by 12pm, on the day before your appointment, in order to keep that time open for you. If we do not receive your confirmation by 12pm, then we reserve the right to place another patient in your allotted time slot. If we fill your appointment time with another patient, then this will be considered a no call/no show. (Please see the missed appointment and cancellation policy below)

**MISSED APPOINTMENT AND CANCELLATION POLICY**

We strive to accommodate everyone's schedule and hope that you will do so in return. If you are unable to keep a scheduled appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment. After a combination of two no show, same day cancellations, you will be required to pay an office visit at the time of scheduling your next appointment. We do this to help keep our times open for you, as well as, keeping times open for other patients who are needing to be seen.

**LATE ARRIVAL POLICY**

When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive 15 minutes or more late, your appointment may be rescheduled in order to meet the needs of those who are on time for their appointment. If we have availability, you may be offered to sit and wait until you can be seen.

Thank you for your understanding of our time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CHANGE IN PHONE NUMBER/ADDRESS/INSURANCE**

Please be sure when checking in with the front desk that we have the correct telephone number, address, and insurance information on file. If your telephone number, address, and/or insurance changes then it is your responsibility to update Horseshoe Dental with this information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT DISMISSAL**

Horseshoe Dental LLC is a private practice and retains the right to dismiss a patient from our practice when it is impossible to resolve differences or when Horseshoe Dental LLC cannot abide the patient's behavior within the practice. When a patient displays a lack of confidence in their dentist's abilities, including but not limited to social media posts; fails to adhere to instructed treatment plans; misses appointments; refuses to pay outstanding fees for agreed-upon payments; or exhibits belligerent behavior, terminating the patient-dentist relationship may be the only option. Horseshoe Dental LLC has the legal ability to dismiss a patient when the patient-dentist relationship has broken down beyond repair.

As always though, please reach out to our office manager in any event that you are not happy with. We strive to keep our patients happy and comfortable and will always be happy to address our patient's concerns.

By signing, I understand the above information and agree with its contents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Response Date:** \_\_\_\_\_