Horseshoe Dental LLC

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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:

Person Responsible for payment:
☐ self ☐ spouse ☐ other

Name:

_____

_____

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

If you are a patient with BOTH private insurance and medicaid insurance, you will be responsible for your private insurance deductible AT TIME OF SERVICE.

We accept all forms of payment at Horseshoe Dental including cash, check, debit card, credit card, and care credit. We do have a 3% fee that we include when accepting debit/credit cards.

Signature _____ **Date** _____

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.

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

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

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

_____

_____

_____

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

Do you take a blood thinner? ○ Yes ○ No

Please list ALL allergies:

What is your estimate of your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician and their specialty:

Most recent physical exam and purpose:

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

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

Name and phone number of preferred pharmacy:

☐ *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:

_____

_____

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?

_____

_____

Please check all that apply:

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

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 recieve 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 accomodate 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 availablity, 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: _____