Loud Family Dental
Dr. Rodrick Loud, DDS
2701 Frederick St.
Shreveport, La 71109

Welcome to our office! To assist us in serving you please complete the following confidential form. The information provided is important to your dental health.

Patient name: ______________________________________ **DOB:** _____________________ **Sex:** ________

SS #: ______________________ **If minor, name of legal guardian :** ___________________________________

Mobile Phone: (_____)_________________________ House Phone: (______)_____________________

Mailing Address: ____ **City:**__________________________

State: ___________ **Zip Code:** ____________ **Email address:** _____________________________________

Preferred Pharmacy ___________________________ **Address:** _____________________________________

Emergency Contact Name: _____________________________ **Tel Number:** ________________________

Can we leave a message with this person: YES / NO **Relation:** ______________________________________

<u>BILLING AND INSURANCE INFORMATION:</u>

☐ **Not covered by Dental Insurance** ☐ **LHI**

Is patient covered by Medicaid: ☐ **YES** ☐ **NO** **Medicaid ID:** _______________________________

If patient is covered by Medicaid, skip to the next page.

Insurance Subscribers Name if different from above: ____

DOB: _____________________ **SS#:** ____________________________ **Relation:**_____________________

Dental Insurance Co: _________________________ **Member ID:** __________________ **Grp #:** __________

Employer: ____ **Tel #:**_____________________________

Secondary Insurance: ____________________________ **Member ID:** ______________ **Grp#:** __________

Insurance Subscribers name: ______________________________________ **DOB:** ______________________

SS#: ___________________________ **Relationship to patient:** ___________________________________

MEDICAL HEALTH HISTORY **Print Patient Name:** ______________________________

Please check any that apply.

Has your doctor ordered you to pre-medicate before any dental treatment?

☐ **Yes** ☐ **No**

☐ Abnormal bleeding after surgery tor trauma
☐ Anemia
☐ Arthritis
☐ Artificial Bones/ Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Back Problems
☐ Bleeding/ Clotting Problems
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer/ Chemotherapy
☐ Cold Sores
☐ Diabetes
☐ Emotional Condition
☐ Epilepsy
☐ HIV/ AIDS
☐ Head/ Neck Injury
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hepatitis
☐ High Blood Pressure
☐ Jaw Pain
☐ Kidney Problems
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Sinus Problems
☐ Stroke
☐ **NONE OF THE ABOVE**

Are you allergic to or have you reacted adversely to any of the following:

☐ Aspirin
☐ Codeine or other narcotics
☐ Dental Anesthetics
☐ Latex
☐ Penicillin
☐ Barbiturates
☐ Metals
☐ Sulfa drugs
☐ Sedatives
☐ **Other:** ______________________________
____
☐ **NONE OF THE ABOVE**

Are you taking any of the following:

☐ Aspirin
☐ Anticoagulants (blood thinners)
☐ High Blood pressure medicine
☐ Antidepressants
☐ Insulin
☐ Orinase
☐ Nitroglycerin
☐ Cortisone or other steroids
☐ Osteoporosis medicine
☐ **Other:** ______________________________
____
____
☐ **NONE OF THE ABOVE**

Tobacco use: ☐ YES ☐ NO

Please specify:

☐ Smoke ☐ Chewing tobacco

Women Only:

Are you pregnant or may be pregnant?

☐ YES ☐ NO

If yes how many weeks: _______________

Name of Physician: ______________________________ **Tel:** ______________________________

Please tell us about any conditions or Medications not listed above:

____
____
____
____
____

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I ______________________________, consent to be a patient at the above named office and
(patient name)
agree to radiographic and clinical examinations. **I also understand and consent to the following:**

1. **During the course of treatment, I may undergo procedures in all phases of dentistry** including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, pediatric dentistry, and radiography.

2. I will provide a **thorough and complete medical history, supply a full list of my medications** with dosage, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history for continuing treatment.

3. **No guarantees can be made about treatment outcomes**, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results or changes in treatment plan.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. **I understand that even if an insurance pre estimate is given or a procedure has been preapproved, I am responsible for any cost that my insurance does not cover.**

5. A **late fee** of 10.00 will be added to an account bi-weekly on any outstanding balance.

6. **I understand that once my account reaches 90 days past due, Loud Family Dental reserves the right to begin the debt collection process.** In the unlikely event that I default on the agreement and a collection agency becomes involved, I could be responsible for any collection costs incurred in addition to my outstanding balance.

7. **All expenses are DUE AT THE TIME OF MY TREATMENT**. We offer three options for payment:
   - Cash, check
   - Credit/debit cards (a merchant fee of 3.95% will be added)
   - We offer CareCredit, a healthcare line of credit

8. I understand that it is very important to keep my appointments to optimize dental benefits, keep on track with my oral health, and keep an active relationship with our office. **We reserve the right to dismiss a patient if there are several missed, failed or cancelled appointments.**

9. **My treatment plan may change at any time** and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist and dental office staff.

10. **I understand that I do not have to accept any treatment** and I am welcome to ask questions about any aspects of my dental care. I will request information if I am confused or need more information regarding my treatment. I am responsible for clarifying any aspects of my dental treatment that I am unsure about.

Patient or Guardian Signature: ______________________________ Date: _______________
Print Name: ____