Hermes & Haynie DDS

6930 Fern Avenue # 100, Shreveport, LA 71105 | Phone: 318-797-9997 | hermesandhayniedds.com | info@hermesandhayniedds.com

Date: _____

Patient Information

Patient Name: _____ _____
Last First MI (Preferred Name)

☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Rev ☐ Male ☐ Female

Employer: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Email: _____

Referral Information

Whom may we thank for referring you to our practice (or did you find us online)? _____

Responsible Party Information (If different from Patient)

Name: _____

☐ Male ☐ Female Relationship to patient: ☐ Spouse ☐ Parent ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SSN/ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SSN/ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

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Date _____

Health Information

Reason for your visit today: _____

I. Please check if taking any of the following medications:

- ☐ Plavix
- ☐ Coumadin
- ☐ Aspirin (includes baby aspirin)
- ☐ Thyroid medicine
- ☐ Inderal, Corgard, Blockadren, Coreg, Cartrol
- ☐ Digitalis
- ☐ Tofranil, Elavil
- ☐ Decongestants
- ☐ ACE Inhibitors - Accupril, Prinivil, Univasc, Vasatec, Captopril
- ☐ Prozac, Paxil, Zoloft, Celexa, Tagamet, Effexar
- ☐ Fosamax, Actonel, Boniva, Zometa I-V
- ☐ Albuterol
- ☐ Birth Control

List all other medications: _____

_____

II. Medical Conditions (Past or Present)

- ☐ Hyperthyroidism
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ COPD/Asthma
- ☐ Pregnant
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Artificial joints
- ☐ Rheumatic heart disease
- ☐ Mitral valve prolapse
- ☐ AIDS

Hepatitis ☐ Type A (food) ☐ Type B (serum/blood) ☐ Type C

List any other medical conditions: _____

_____

III. Allergies

- ☐ Penicillin
- ☐ Codeine
- ☐ Bisilfites (fresh fruits)
- ☐ Sulpha Drugs
- ☐ Keflex
- ☐ Tetracyclines
- ☐ Latex

List all other allergies _____

IV. Dental Information

☐ Yes ☐ No Have you been examined by a dentist in the last year. If no, how long? _____
☐ Yes ☐ No Do you grind your teeth?
☐ Yes ☐ No Do you like the color of your teeth?
☐ Yes ☐ No Do you drink carbonated beverages?
☐ Yes ☐ No Do you smoke/or use any other tobacco products?
☐ Yes ☐ No Have you had radiation treatment in head/neck area?
☐ Yes ☐ No Have you been advised to be premedicated with antibiotic prior to dental work?
☐ Yes ☐ No Would you like to talk about being sedated to relieve anxiety prior to dental work?

_____
Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____, have read and received a copy of this offices Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Today's Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____