Ronald C. Hermes, D.D.S. · 6930 FERN AVENUE, SUITE 100 · SHREVEPORT, LA 71105 · 318.797.9997 · Fax 318.797.9990

Date: ______________________

Patient Information

Patient Name: ______________________________ (Last / First / MI) ______________________ (Preferred Name)

☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Rev ☐ Male ☐ Female Employer: ______________________

SS#: ______________ Birth Date: ______________ Email: ______________________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address: ______________________________ (Street / Apartment #)

______________________________ (City / State / Zip Code)

Referral Information

Whom may we thank for referring you to our practice? ______________________

Responsible Party Information
(If different from patient)

Name: ______________________ ☐ Male ☐ Female Relationship to patient: ______________

SS#: ______________ Birth Date: ______________ Email: ______________________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address: ______________________________ (Street / Apartment #)

______________________________ (City / State / Zip Code)

Dental Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

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

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: ______________________

Medical History Please Check

1. Are you in good health? Yes ☐ No ☐
2. Do you have diabetes? Yes ☐ No ☐
3. Do you smoke or use any other tobacco products? Yes ☐ No ☐
4. Do you have high blood pressure? Yes ☐ No ☐
5. Do you have any heart ailments? Yes ☐ No ☐
6. Do you have any lung disease or asthma? Yes ☐ No ☐
7. Do you have hepatitis or liver disease? Yes ☐ No ☐
8. Do you have kidney disease? (If dialysis please circle yes) Yes ☐ No ☐
9. Do you have a history of seizures? Yes ☐ No ☐
10. Do you have any blood diseases? (HIV, AIDS, von Willebrands, etc.) Yes ☐ No ☐
11. Do you take any blood thinners or fish oil? (Aspirin, Coumadin, Plavix, etc.) Yes ☐ No ☐
12. Are you taking any medications now? (including over the counter medication) Yes ☐ No ☐
    If yes, please list: ______________________________
    ____
13. Have you been ill or hospitalized recently? Yes ☐ No ☐
14. Are you receiving any medical treatment now? Yes ☐ No ☐
    If yes, please list: ______________________________
    ____
15. Please enter your physicians name: ______________________________
16. Are you allergic to any medications? (including over the counter medication) Yes ☐ No ☐
    If yes, please list: ______________________________
    ____
17. Have you ever received radiation treatment in the head or neck region? Yes ☐ No ☐
18. Are you pregnant or nursing? (women) Yes ☐ No ☐
19. Have you ever taken medication for osteoporosis or bone cancer? Yes ☐ No ☐
20. Have you ever had a fractured jaw? Yes ☐ No ☐
21. Have you been told that you snore? Yes ☐ No ☐
22. Have you been examined by a dentist in the last year? ☐Yes ☐ No If no, how long?______________
23. Do you like the appearance of your teeth or smile? Yes ☐ No ☐
24. Would you like to talk about being sedated to relieve anxiety prior to your next visit? Yes ☐ No ☐

My medical history is accurate and complete.

______________________________ ______________

Patient Signature Date

Ronald C. Hermes, D.D.S.

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Shreveport, LA 71105
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Payment Agreement

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within ten (10) days of billing if credit shall be extended.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature: ______________________________ Relationship to Patient: ____________________

Date: ______________________________

Ronald C. Hermes, D.D.S.

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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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify):

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