Fern Avenue Dentistry

Thank you for choosing our office to contribute to your dental health and well-being. Most of our patients come by referral. When one recommends us to a friend, we consider it a great compliment. We value your opinion and will appreciate you as a patient in our practice. We welcome any questions, concerns, or suggestions you have about our services or office protocol.

We take pride in two things, how we treat our guest and the quality of our work. To us these are inseparable. Quality is critically important to us because for us it's not enough to say we care – we need to demonstrate our commitment. Our mission of caring directs everything in our office including taking advanced, specialized training in major areas of dentistry so we can provide a full range of treatment, including preventive, restorative, and cosmetic dentistry.

We hope you are comforted to know that our office strives to meet your dental needs at a high level. All of us really love this work and feel fulfilled when the results are excellent and when we become friends. We hope this letter has conveyed the sense of pride with which we do our work and how important this work is to us, and why we are pleased you have chosen to become part of our office.

Thank you for being our guest!

Dr. Black and Staff

IMPLANT DENTISTRY

Do you have gaps in your mouth from missing teeth? Tired of dentures that won't stay put?

Implants may be an option for you.

PATIENT FINANCING

Have you been putting off dental treatment, or completing your treatment plan in phases due to budget constraints?

Be sure to inquire about our patient financing options

COSMETIC DENTISTRY

Your smile says a lot about you. Do you wish you had a more dazzling smile?

Whether it's simple teeth whitening or a complex smile makeover.

HEADACHE THERAPY

We are proud to offer our patients an FDA approved device to help prevent migraine & tension-type headaches.

Relief guaranteed or your money back!

PERSONAL INFORMATION

Married / Single

Mr./Mrs./Ms/Miss/Dr._____-_____ Widowed / Divorced

Last *First* *Middle Initial* *Preferred Name*

Address_____City_____State_____Zip_____

Home Ph_____ Work Ph_____ Cell _____

Social Security # _____ Date of Birth____/____/____ Occupation_____

Employer_____ Email_____ Do you check daily? _____

Have we seen anyone else in your family? □ No □ Yes If yes: _____

Name & phone number of nearest relative not living with you: _____

HOW DID YOU HEAR ABOUT OUR OFFICE*?* _____

MEDICAL HISTORY

Do you have or ever had any of the following? Please check either Yes or No as applicable.

Artificial Joints	□ No	□ Yes	Diabetes	□ No	□ Yes	Drug Addiction	□ No	□ Yes
Hepatitis (□ A □ B or □ C)	□ No	□ Yes	Rheumatic Fever	□ No	□ Yes	Osteoporosis	□ No	□ Yes
High Blood Pressure	□ No	□ Yes	Heart Murmur	□ No	□ Yes	HIV/AIDS	□ No	□ Yes
Cancer	□ No	□ Yes	Fainting Spells	□ No	□ Yes	Kidney Problems	□ No	□ Yes
Lung Problems / TB	□ No	□ Yes	Asthma	□ No	□ Yes	Radiation Therapy	□ No	□ Yes
Bleeding Problems (excluding bleeding gums)	□ No	□ Yes	Epilepsy, Seizures	□ No	□ Yes	Headaches / Migraines	□ No	□ Yes

ALLERGIES – HYPERSENSITIVITIES

Penicillin	□ No	□ Yes	Aspirin	□ No	□ Yes	Codeine	□ No	□ Yes
Anesthetic	□ No	□ Yes	Latex	□ No	□ Yes	Other _____	□ No	□ Yes

Are you under a physician's care now? If yes:_____

Are there any other health related issues you would like to make us aware of? _____

_____

Have you been hospitalized in the last two years? □ No □Yes If yes, please explain. _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? _____

Do you use tobacco?_____

Please list any drugs (Rx or OTC) currently being taken. _____

_____

I hereby authorize Fern Avenue Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Black to make a thorough diagnosis of my dental needs. I also authorize Dr. Black to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

I further authorize the use of my name or a photograph(s), video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for advertising, education, or any other lawful purpose and I release and forever discharge him from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

I have received and reviewed a copy of this office's Notice of Privacy Practices.

Signature of patient _____**Date**_____

INSURANCE AUTHORIZATION

Insurance Carrier_____ Employer_____

Subscriber Name_____ Subscriber ID (S.S. #)_____

Subscriber Date of Birth_____ Group #_____

Insurance Address (Claims Address)_____

City_____State_____Zip Code_____Phone_____

Do you have secondary insurance? ☐ **Yes** ☐ **No**

WHAT ARE YOUR FEELINGS ABOUT YOUR:

Esthetics

Would you like to improve the way your teeth look? □ No □ Yes
If yes, please explain.

Function

Are there any foods that you cannot eat but would like to? □ No □ Yes
If yes, please explain.

Comfort

Are you experiencing any pain or sensitivity from any of your teeth? □ No □ Yes
If yes, please explain.

Do you experience anxiety associated with dental work? □ No □ Yes

WHAT IS THE FIRST THING YOU WOULD LIKE FOR US TO HELP YOU WITH?

HIPAA Notice of Privacy Practices

Fern Avenue Dentistry
Johnny Black, DDS
8535 Fern Avenue
Shreveport, LA 71105

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CARRFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that relates to your past, present, or future physical mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required by Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services in investigate or determine our compliance with the requirements of Section 164.500.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

Other Permitted Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before **February 16, 2026**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____Date:_____