Craig S. Landry, DDS

350 Doucet Rd., Suite 101 • Lafayette, LA 70503 • Phone 337-981-9242 • Fax 337-984-2763
Website: www.drcraiglandry.com • E-mail: craig@drcraiglandry.com

Patient Information

Date _____

Patient's Name _____ Single ____ Married ____ Widowed ___ Divorced ___

Address _____
Street City State Zip

E-mail address _____

Home Phone _____ Work Phone _____ Cell # _____

Birthdate _____ S.S# _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's name _____

Spouse's employer _____

Occupation _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ if yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of person to be contacted in the event of an emergency _____

Complete address _____

Home Phone _____ Work Phone _____

I authorized release of information to my insurance companies.

Signature (Patient or Parent) _____

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MEDICAL HISTORY

Patient's Name_____ Date_____

Please check the blank for any condition that you have had in the past or have now.(Parent or guardian: If you are completing this form for your child, please indicate your child's health status by checking the appropriate blank.)

1. CARDIOVASCULAR
- __ Heart failure
- __ Heart disease or attack
- __ Angina pectoris or chest pain
- __ Heart murmur
- __ Mitral valve prolapse
- __ Rheumatic Fever
- __ Congenital heart defects
- __ High Blood Pressure
- __ Heart pacemaker or defibrillator
- __ Heart surgery or transplant
- __ Other heart problems
- __ Stroke
- __ Aneurysm
- __ Artificial heart valve
- __ Arrhythmias

2. HEMATOLOGIC
- __ Blood transfusions
- __ Anemia
- __ Hemophilia
- __ Leukemia
- __ Sickle cell (anemia) disease
- __ Tendency to bleed excessively

3. NEURAL and SENSORY
- __ Eye pain
- __ Glaucoma or cataract
- __ Vision problems
- __ Earaches, ringing in ears
- __ Hearing loss
- __ Fainting or dizzy spells
- __ Severe headaches
- __ Epilepsy, seizures or convulsions
- __ Psychiatric treatment
- __ Nervousness

4. GASTROINTESTINAL
- __ Stomach or intestinal ulcers
- __ Gastritis
- __ Colitis
- __ Persistent diarrhea
- __ Hepatitis
- __ Liver disease
- __ Yellow jaundice
- __ Cirrhosis

5. RESPIRATORY
- __ Hay fever
- __ Sinus trouble
- __ Allergies or hives
- __ Chronic cough
- __ Tuberculosis(TB)
- __ Breathing difficulties
- __ Emphysema
- __ Asthma

6.DERMAL/MUSCULOSKELETAL
- __ Allergy to latex (rubber)
- __ Skin rash
- __ Dark mole(s) (recent changes in appearance)
- __ Night sweats
- __ Sore muscles
- __ Stiff joints
- __ Arthritis
- __ Artificial joint
- __ Fever blister
- __ Mouth ulcers or canker sores
- __ Colored or discolored areas in mouth

7.ENDOCRINE
- __ Diabetes
- __ Thyroid disease

8.URINARY-SEXUALLY TRANSMITTED
- __ Urinate frequently
- __ Kidney, bladder problem
- __ Sexually transmitted disease (syphilis, gonorrhea,chlamydia genital herpes)
- __ HIV-positive (AIDS)

9.OTHER CONDITIONS
- __ Frequent sore throats
- __ Enlarges lymph node or "gland
- __ Use alcohol
- __ Drug addiction
- __ Tumor or cancer
- __ X-ray or cobalt treatment
- __ Chemotherapy
- __ Use tobacco
- __ Disease or problem not listed

If yes, list

_____
_____
_____

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MEDICAL HISTORY (cont'd)

	YES	NO
10. Are you currently under the care of a physician?		
Physician name_____ Address_____	—	—
Phone no._____ Last appointment _____		
For what reason_____		
11. Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind?		
If yes, what kind and dose?	—	—
_____		
_____		
_____		
12. Have you taken cortisone or other steroids in the past 12 months?	—	—
13. Do you have reactions or allergies to drugs or medicines?	—	—
If yes, what drug or medicine? _____		
14. Have you had a reaction to dental or general anesthesia?	—	—
15. Have you ever had an operation or surgery?	—	—
List the surgeries and any complications		
_____		
16. Have you ever been hospitalized?		
If yes, explain the reason(s)_____	—	—
17. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired?	—	—
18. Do your ankles swell during the day?	—	—
19. Do you sleep on two or more pillows?	—	—
20. Have you unintentionally lost or gained more than 10 pounds in the past year?	—	—
21. Are you on a special diet?	—	—
22. Does your occupation bring you into contact with blood, blood products, or needles?	—	—
23. WOMEN: ARE YOU PREGNANT?	—	—

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

_____	_____	_____
Date	Patient, parent or guardian signature	Dentist's signature

**********FOR OFFICE USE ONLY**********

Height_____ Weight_____ BP____/____ HR___Resp___

HEALTH COMMENTS AND SUMMARY: ASA I II III IV

_____

_____

_____

_____

Head & Neck Symptoms Form

Name _____ Date _____

Please mark ANY symptoms you may have, no matter what the cause may be.
(jaw pain, sinus pain, muscle pain in face, head or neck and shoulder areas)

SYMPTOMS

(jaw)

	Right	Left
1. Pain in jaw joint	☐ R	☐ L
2. Pain in ear	☐ R	☐ L
3. Pain in temples	☐ R	☐ L
4. Clicking, Popping, grating injaw joints	☐ R	☐ L
5. Hearing loss	☐ R	☐ L
6. Ringing in ears	☐ R	☐ L
7. Pressure or fullness in ears	☐ R	☐ L
8. Do you chew gum?	☐ Y	☐ N

-How often? _____

(mouth)

1. Do you have any pain in your tongue? ☐ Y ☐ N
2. Do you bite your tongue? ☐ Y ☐ N
3. Do you have any white lines on your tongue? ☐ Y ☐ N
4. Is your mouth opening limited? ☐ Y ☐ N
   - -With what causes limited opening?
   - -Explain
   - -Always happens
   - -Sporadically happens
5. Do you have any difficulty chewing? ☐ Y ☐ N
6. Do you have any difficulty swallowing? ☐ Y ☐ N
   - How often? _____ with what do you have difficulty swallowing? _____

   _____
7. Do you breath with your mouth open at night? ☐ Y ☐ N
8. Do you awaken with dry mouth? ☐ Y ☐ N

-How often? _____ (daily) _____

(sporadic) _____

(teeth)

1. Do you have any missing teeth? ☐ Y ☐ N
2. Do you have any loose teeth? ☐ Y ☐ N
3. Do you clinch or grind your teeth? ☐ Y ☐ N
4. Do you have any hot & cold sensitive teeth? ☐ Y ☐ N

(head, neck)

1. Do you have pain behind your eyes? ☐ Y ☐ N
2. Do you have neck pain? ☐ Y ☐ N
3. Do you have pain in shoulders? ☐ Y ☐ N
4. Do you have pain in your forehead? ☐ Y ☐ N
5. Do you have pain in your facial muscles? ☐ Y ☐ N
6. Do you have any dizziness (vertigo)? ☐ Y ☐ N
7. Do you have headaches? ☐ Y ☐ N

7a. How often do you have headaches?

___ daily - ___ weekly (how many days) ___

___ monthly (how often) ___

Are these headaches migraine headaches and do you take any medicine for them? ☐ Y ☐ N

Please list the medications you take for your headaches. _____

8. Do you have upset stomach nausea from headaches? ☐ Y ☐ N
9. Do you have any postural problems? ☐ Y ☐ N
10. Do you change positions often to be comfortable? ☐ Y ☐ N

(nerves)

1. Do you have any tingling in your finger tips? ☐ Y ☐ N
2. Do you experience any nervousness/ anxiety/or insomnia (difficulty sleeping)? ☐ Y ☐ N
3. Bell's Palsy ☐ Y ☐ N
4. Trigeminal neuralgia? ☐ Y ☐ N

(misc)

1. Do you experience loud snoring? ☐ Y ☐ N
2. Are you constantly tired? ☐ Y ☐ N
3. Do you bite your cheeks? ☐ Y ☐ N
   ☐ R ☐ L
4. Have you ever seen a doctor for sinus or allergy problems in the past? ☐ Y ☐ N

   If so were you diagnosed with a particular problem and please list . _____

5. Have you ever had sinus surgery? ☐ Y ☐ N
6. If so did it give you any relief? ☐ Y ☐ N

7a. Have you ever seen a chiropractor to help relieve pain? ☐ Y ☐ N

b. If so did you get any relief? ☐ Y ☐ N

c. How often do you see your chiropractor?

_____ weekly _____ monthly

d. What is the main reason for seeing your chiropractor? _____

8. Do you wake up in the morning and have to stretch your jaw muscles? ☐ Y ☐ N

9. Where is your primary source of pain and what triggers it? _____

_____

_____

_____

10. Where do you experience the most pain in the head, neck and shoulder areas?_____

_____

_____

_____

11.How often do you experience this pain?

____ daily

____ weekly (How many days per week? ____)

____ monthly (How often in a months period of time? ___)

Please rate your pain on a scale of 1 to 10. (1 being the least amount of pain and most comfortable and 10 being the worst pain)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Craig S. Landry, DDS

Smile Evaluation

We would like to help you obtain the smile you have always wanted. Please take a few minutes to complete this short questionnaire.

1. Do you have any concerns about bad breath? _____

_____

2. Are you pleased with the appearance of your teeth when you smile? _____

_____

3. Are you pleased with the color of your teeth? _____

_____

4. Are you pleased with the shape of your teeth? _____

_____

5. Are there spaces between your teeth that you don't like? _____

_____

6. Are your teeth
Chipped? _____ **Protruding?** _____ **Hidden?** _____ **Crowded?** _____

7. Do you like the way your teeth fit together when you bite? _____

_____

8. Are there old fillings or dental treatment that you aren't happy with? _____

_____

9. If you could change anything about the appearance of your smile, what would that be? _____

_____

10. Is there anything about the shape or alignment of your jaws that you are not happy with? _____

11. Please rate your smile. 1 2 3 4 5 6 7 8 9 10 (10 as being excellent)

12. Would you like to have straighter teeth? Yes or No

13. Have you heard of Invisalign? Yes or No

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Craig S. Landry, DDS APDC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kathy Moy _____

Telephone: 337 981 9242 _____ Fax: 337 984 2763_____

E-mail: craigdds@cox-internet.com _____

Address: 350 Doucet Road Suite 100, Lafayette, LA 70503 _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____(Print), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Craig S. Landry, DDS

GENERAL & Cosmetic Dentistry

Financial Policy

Our financial policy is designed to make it affordable for you to have the dental care that you need or want. We have worked very hard to create various payment options for our patients, and have come up with financial arrangements that will allow virtually anyone to have the very best dentistry available, at a very affordable cost.

We accept Visa, Mastercard, and American Express credit cards. Cash or check is also acceptable. Monthly payment plans are available, with various interest free periods for larger treatment for those of you who wish to spread payments over a period of time.

Most dental insurance plans are accepted, however we are not part of any PPO or HMO plans. With regard to dental insurance, we will help you to file all claims for any treatment provided by us. You will be responsible for all fees that are incurred by you for any treatment rendered.

For those of you with insurance, we will allow you to pay your copayment (plus any deductible) at the time of treatment and will allow the insurance company to pay the amount that they decide to pay. We will allow this for 1 month (30 days) from the date that the claim is filed. At the end of 30 days, the balance that remains for the treatment provided will be due from you regardless if the insurance company has paid or not. We will always be committed to helping you get the money due to you from the insurance company in a timely manner, but we cannot carry balances on our books for more than 30 days. If your insurance company takes more than 30 days to process your claim, we have comfortable payment options available for you to take care of your balance at that time.

I have read the above financial policy and agree to comply accordingly.

Signed:_____

Date: _____

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Craig S. Landry, DDS

GENERAL & Cosmetic Dentistry

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand, we are ready to answer any of your questions or explain anything.

Any alternatives to the recommended treatment, including no treatment, have been explained to me.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

Infection
Bleeding
Failure of wound to heal
Injuries to adjacent teeth and/or hard or soft tissues
Paresthesia or numbness of Tongue, and/or mouth, and/or face
Fracture of mandible(lower jaw) or maxilla (upper jaw)
Opening between mouth and sinus or mouth and nose
Tooth or fragment in maxillary sinus
Incomplete removal of tooth
Dry socket
Loss of teeth
Loss of bone
Slough (unanticipated loss of hard and/or soft tissue)
Injury to adjacent structures
Instrument breakage
Breakage of root(s) and retained root fragments
Swallowing and/or aspiration of objects
Allergic reaction to drugs
Trismus (jaw pain or difficulty opening mouth)
Failure of treatment to accomplish it's purpose
Bacterial Endocarditis
Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

ACKNOWLEDGMENT

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any question and all questions that were asked, were answered to my satisfaction.

I hereby authorize and direct Dr. Craig Landry and/or his associates, hygienists, assistants to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

Date:_____ Signature of patient or guardian_____

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