Dr Thomas Sammons & Dr Ann Laurent
Dental Artistry

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help!

PATIENT INFORMATION *(CONFIDENTIAL)*

Name_____ Birthday_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married Social Security # _____-_____-_____

If Student, Name School/College_____ City_____ State_____

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Person to Contact in Case of Emergency_____ Phone_____

We would love to hear how you found out about us: Please Check: ☐ Radio_____ *(which station)* ☐ Google

☐ Patient Referral _____ ☐ Sammonsdds.com ☐ 6month Smiles ☐ Other _____*(please list)*

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Driver's License #_____ Birthday _____

Is this Person Currently a Patient in Our Office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

If you already faxed in your information this section is not required.

Name of Insured_____ Relationship to Patient_____

Birthday_____ Social Security # _____-_____-_____

Name of Employer _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____City_____ State_____ Zip_____

Over please

101 West Martial Avenue | Lafayette, LA 70508 | Tel: (337) 406-1110 | Fax (337) 406-1113

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

	Y	N
1. Are you under medical treatment now?	☐	☐
2. Are you taking any medication(s) including non-prescription medicine?	☐	☐
a. If yes, which medication(s) are you taking? _____		
3. Do you use tobacco?	☐	☐
4. Are you wearing contact lenses	☐	☐
5. Women Only		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

6. Are you allergic to or have had reactions to any of the following?	Y	N
a. Local anesthetics (e.g. Novocaine or Codeine)	☐	☐
b. Penicillin or other Antibiotics	☐	☐
c. Sulfa drugs	☐	☐
d. Barbiturates	☐	☐
e. Sedatives	☐	☐
f. Iodine	☐	☐
g. Aspirin	☐	☐
h. Any metals (e.g. nickel, mercury, etc.)	☐	☐
i. Latex rubber	☐	☐
j. Other (please list)	☐	☐

7. Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
a. High blood pressure	☐	☐	n. Heart disease/surgery	☐	☐	aa. Mood disorders	☐	☐
b. Heart attack	☐	☐	o. Cardiac pacemaker	☐	☐	bb. Anxiety/depression	☐	☐
c. Rheumatic fever	☐	☐	p. Heart murmur	☐	☐	cc. Stroke/chest pain	☐	☐
d. Swollen ankles	☐	☐	q. Angina	☐	☐	dd. Hay fever/allergies	☐	☐
e. Fainting/seizures	☐	☐	r. Frequently tired	☐	☐	ee. Tuberculosis	☐	☐
f. Asthma	☐	☐	s. Anemia	☐	☐	ff. Radiation therapy	☐	☐
g. Low blood pressure	☐	☐	t. Emphysema	☐	☐	gg. Glaucoma	☐	☐
h. Epilepsy/convulsions	☐	☐	u. Cancer	☐	☐	hh. Recent weight loss	☐	☐
i. Leukemia	☐	☐	v. Arthritis	☐	☐	ii. Liver disease	☐	☐
j. Diabetes	☐	☐	w. Joint replacement or implant	☐	☐	jj. Excessive day time sleepiness	☐	☐
k. Kidney diseases	☐	☐	x. Hepatitis/jaundice	☐	☐	kk. Do you snore or has anyone ever told you that you snore?	☐	☐
l. AIDS or HIV infection	☐	☐	y. Sexually transmitted disease	☐	☐			
m. Thyroid problem	☐	☐	z. Stomach troubles/ulcers	☐	☐			

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____

1. Do your gums bleed while brushing or flossing? ☐ YES ☐ NO
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ YES ☐ NO
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ YES ☐ NO
4. Do you feel pain to any of your teeth? ☐ YES ☐ NO
5. Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO
6. Have you had any head, neck, or jaw injuries? ☐ YES ☐ NO
7. Have you owned any of the following appliances?
   ☐ NTI Night Guard ☐ Snoring Appliance ☐ CPAP ☐ Retainer
   How often do you wear the appliance _____
8. How often do you awaken with head/jaw pain of unknown origin?
   ☐ Every morning ☐ Once or twice a week
   ☐ Few times a month ☐ Never
9. Have you ever had any prolonged bleeding following extractions? ☐ YES ☐ NO
10. Have you ever had any orthodontic treatment?
    ☐ YES ☐ NO
11. Do you like your smile? ☐ YES ☐ NO

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above wuestions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependent's behalf.

X_____ _____

Signaure of patient (or parent if minor) Doctor's Signature Date