Stacey L Lowman, D.D.S., Inc.
A Professional Dental Corp.
Family Dentistry

CONFIDENTIAL PATIENT HEALTH RECORD

NAME:_____ D.O.B._____ SSN:____/____/____
(Last) (First) (M.I.)

Address:_____ Home#_____
(Street)

_____ Cell#_____
(City) (State) (Zip)

Check appropriate Box: ❑ Minor ❑ Single ❑ Married

RESPONSIBLE PARTY:_____ Relationship to Patient:_____

D.O.B.:_____ Driver's License#_____ SSN:____/____/____

Address:_____ Home Phone:_____

Name/Address of Nearest Relative:_____ Phone:_____
(In Case of Emergency)

Your E-Mail Address:_____ Referred By:_____

MEDICAL HEALTH

General Health (please check): ❑EXCELLENT ❑GOOD ❑FAIR ❑POOR Last physical exam _____
Are you taking any medications now? ❑YES ❑NO For what purpose?_____
Name of Physician:_____ Phone:_____
Address of Physician:_____
Which medications?_____
Do you require antibiotics before routine dental treatment? ❑YES ❑NO
Have you ever had any radiation therapy? ❑YES ❑NO Fen-Phen/Redux ❑YES ❑NO
Are you allergic to: ❑ Penicillin ❑ Codeine ❑Novacaine/Epinephrine ❑Latex ❑ Other _____

Women: Are you pregnant? ❑ YES ❑ NO If yes, how long?_____(months)
Advisory: Antibiotics may render birth control medications ineffective.

Have you ever been treated for:

Heart Disease	❑YES ❑NO	Thyroid Problems	❑YES ❑NO	Tuberculosis or Lung Disease	❑YES ❑NO
Rheumatic Fever	❑YES ❑NO	Diabetes	❑YES ❑NO	Sinus Trouble	❑YES ❑NO
High/Low Blood Pressure	❑YES ❑NO	Epilepsy/Seizures	❑YES ❑NO	Arthritis	❑YES ❑NO
Angina/Chest Pain	❑YES ❑NO	Fainting/Dizziness	❑YES ❑NO	Bisphosphonate Medication	❑YES ❑NO
Heart Murmur	❑YES ❑NO	Sexually transmitted diseases	❑YES ❑NO	Osteoporosis	❑YES ❑NO
Cardiac Pacer	❑YES ❑NO	AIDS or HIV Infection	❑YES ❑NO	Glaucoma	❑YES ❑NO
Anemia	❑YES ❑NO	Hepatitis	❑YES ❑NO	Joint Replacement/Implant	❑YES ❑NO
Congenital Heart Failure	❑YES ❑NO	Liver Disease/Jaundice	❑YES ❑NO	Cortisone/Steroid Medicine	❑YES ❑NO
Stroke	❑YES ❑NO	Kidney Disease	❑YES ❑NO	Cancer	❑YES ❑NO
High Cholesterol	❑YES ❑NO	Ulcer/Stomach Troubles	❑YES ❑NO	Phobias/Nervous Anxious	❑YES ❑NO
Pacemaker	❑YES ❑NO	Asthma or hay fever	❑YES ❑NO	TMJ Disorder	❑YES ❑NO
Prolonged Bleeding	❑YES ❑NO	Infectious/Contagious Disease	❑YES ❑NO	Mental Disorders	❑YES ❑NO

DENTAL HEALTH

Reason for visit: _____ When was your last dental visit? _____
Prior dentist name: _____ What was your last treatment? _____
Have you ever had any serious medical problem associated with previous dental treatment? ❑YES ❑NO
if yes, explain: _____

How often do you brush your teeth? _____times/day. ♦Smoke Tobacco? ❑Yes ❑No _____cigarettes/day
What texture tooth brush do you use? ❑Soft ❑Medium ❑Hard
Do you floss daily? ❑Yes ❑No Do your gums bleed when flossing or brushing? ❑Yes ❑No
Do your gums feel tender or swollen? ❑Yes ❑No
Do you feel pain when your teeth come in contact with: ❑Hot ❑Cold ❑Sweets ♦Gagging easily? ❑Yes ❑No
Do you chew on one side of your mouth? ❑Yes ❑No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ❑Yes ❑No
Do your jaws ever feel tired? ❑Yes ❑No ♦Do your jaws "pop" or "click"? ❑Yes ❑No ♦Facial Pain? ❑Yes ❑No
Numbness in lower lip or jawbone ❑Yes ❑No
Would you like to change anything about your smile? ❑Yes ❑No
If yes, explain: _____
Do you feel your oral condition is affecting your general health in any way? _____
_____
Please add anything you feel is important: _____
_____

INSURANCE INFORMATION

Name of Insured: _____ DOB _____ SSN# _____ Relationship to patient _____
Employer: _____ Address _____
Insurance Company: _____ GROUP# _____ Policy# _____
Additional Insurance: ❑Yes ❑No
Name of Insured: _____ DOB _____ SSN# _____ Relationship to patient _____
Employer: _____ Address _____
Insurance Company: _____ GROUP# _____ Policy# _____
If patient is a student, Name of School/College _____

I, the undersigned, hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursements, directly to the Dental Provider, of insurance benefits under which I am entitled. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

_____ _____
(DATE) (SIGNATURE)

INFORMED CONSENT

1. I am responsible for *ALL* charges related to services provided to me at the usual and customary charges of the dental office.
2. I hereby grant authority to the dentist(s) in charge of my care to administer treatment, anesthetics or drugs and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks, benefits, alternatives and possible consequences of the treatment proposed and I authorize the treatment.
3. Dental treatment may include examination, x-rays, cleaning, gum disease treatment, fillings, root canals, extractions and prosthodontics usually with local anesthesia. If the cavity in the tooth is very deep, the removal of the nerve or the tooth may be necessary. We would like to provide you with complete information regarding the risks and benefits of your dental treatment.
4. I was provided with THE DENTAL MATERIALS FACT SHEET as required by California Law. I also under stand that The Fact Sheet would be provided to me anytime in the future upon my request.

SIGNED X _____ DATE _____