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

CONFIDENTIAL PATIENT HEALTH RECORD

Name: _____ Preferred Name: _____
(Last) (First) (M.I.)

Check Appropriate Box: ☐ Minor ☐Single ☐Married

Date of Birth: _____ SSN: _____ E-mail Address: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Referred By: _____

Name of Emergency Contact/Relationship to Patient: _____ Phone: _____

MEDICAL HEALTH

Are you currently under a physician's care? ☐ Yes ☐ No
If yes, please explain: _____
Have you been hospitalized or had a major operation within the last year? ☐ Yes ☐ No
If yes, please explain: _____
Are you taking any medications now? ☐ Yes ☐ No If yes, for what purpose? _____
Which medications: _____

Do you require antibiotics before routine dental treatment? ☐ Yes ☐ No
Have you ever had any radiation therapy? ☐ Yes ☐ No
Have you ever used Fen-Phen or Redux? ☐ Yes ☐ No
Are you allergic to: Latex ☐ Yes ☐ No Codeine ☐ Yes ☐ No
Novocain/Epinephrine ☐ Yes ☐ No Penicillin ☐ Yes ☐ No
Other – Explain: _____

Women: Are you pregnant? ☐ Yes ☐ No If yes, how long? _____ (months)

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

Mitral Valve Prolapse	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Osteoporosis/Osteopenia	☐ Yes ☐ No
High/Low Blood Pressure	☐ Yes ☐ No	Autoimmune Disease	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Angina/Chest Pain	☐ Yes ☐ No	STD	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	AIDS or HIV Infection	☐ Yes ☐ No	Cortisone/Steroid Med.	☐ Yes ☐ No
Congenital Heart Failure	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Bisphosphonate Med.	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Liver Disease/Jaundice	☐ Yes ☐ No	TMJ Disorder	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Ulcer/Stomach Troubles	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Tuberculosis/Lung Disease	☐ Yes ☐ No	Fainting/Dizziness	☐ Yes ☐ No
Prolonged Bleeding	☐ Yes ☐ No	Asthma or Hay Fever	☐ Yes ☐ No	Nervous Disorders	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Alzheimer's Disease	☐ Yes ☐ No
				Other_____	

DENTAL HEALTH

Reason for visit: _____
When was your last dental visit? _____ What was your last dental treatment? _____
Have you ever had any serious medical problem associated with previous dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

How often do you brush your teeth? _____ times a day Texture of toothbrush used: ☐ Soft ☐ Medium ☐ Hard
Do you floss daily? ☐ Yes ☐ No Gag Easily? ☐ Yes ☐ No
Do your gums feel tender or swollen? ☐ Yes ☐ No Do your jaws "pop" or "click"? ☐ Yes ☐ No
Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No
Do you feel pain when your teeth come in contact with: ☐ Hot ☐ Cold ☐ Sweets
Do you: ☐ Smoke Tobacco ☐ Chew Tobacco ☐ Vape ☐ Smoke Marijuana

Would you like to change anything about your smile? ☐ Yes ☐ No
If yes, please explain: _____
Please add anything you feel is important: _____
_____

INSURANCE INFORMATION

Name of insured: _____ DOB: _____ SSN: _____ Relationship to patient: _____
Employer: _____ Insurance company: _____ Member ID: _____
Insurance phone number: _____ Group number: _____
Additional insurance? ☐ Yes ☐ No
Name of insured: _____ DOB: _____ SSN: _____ Relationship to patient: _____
Employer: _____ Insurance company: _____ Member ID: _____
Insurance phone number: _____ Group number: _____

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 understand that the Fact Sheet would be provided to me anytime in the future upon my request.

Signed_____ Date_____