JEFFREY A. LOWRY, DDS
FAMILY DENTISTRY

Jeffrey A Lowry DDS
3769 McCray Street
Riverside, CA 92506
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New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient Information

First Name: | Middle Name: | Last Name:

Sex: | Date of Birth (mm/dd/yyyy): / / | Social Security #: - -

Home Phone: - - | Cell Phone: - - | E-mail Address:

Home Address: | City: | State: | ZIP Code:

Occupation:

Was our website a factor in your decision to visit our practice? ❍Yes ❍No

Emergency Contact

Title: | First Name: | Last Name: | Relationship to Patient:

Home Phone: - - | Cell Phone: - -

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / /

Dental History

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

Yes

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Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Loose/missing filling	❑ Missing teeth	❑ Sensitive to sweets
❑ Crooked	❑ Loose teeth	❑ Mouth sores	❑ Blisters on lips/mouth
❑ Decay	❑ Tooth pain	❑ Sensitive to cold	❑ Orthodontic treatment
❑ Difficulty chewing	❑ Food trap areas	❑ Sensitive to heat	❑ Bad taste in mouth
❑ Discolored	❑ Grinding or clenching	❑ Sensitive when biting	

Medical History

Do we have permission to contact your doctor regarding your care? ❍ Yes ❍ No

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Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Arteriosclerosis
- ❑ Birth defects
- ❑ Cancer
- ❑ Emotional problems
- ❑ Head or face injury
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Kidney problems
- ❑ Numbness of arms or hands
- ❑ Swollen, still painful joints
- ❑ Allergies
- ❑ Asthma
- ❑ Blood disease
- ❑ Diabetes
- ❑ Endocrine problems
- ❑ Intestinal disorders
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Bruise easily
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Seizures
- ❑ Fainting
- ❑ Hearing disorders
- ❑ High or low blood sugar
- ❑ Hypotension (low blood pressure)
- ❑ Nervous disorder
- ❑ Rheumatic fever
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Artificial valves
- ❑ Congenital heart defect
- ❑ Mitral valve prolapse
- ❑ Artificial bones/joints
- ❑ Shingles
- ❑ HIV/AIDS
- ❑ Blood transfusions
- ❑ Fever blisters
- ❑ Sinus problems
- ❑ Severe/frequent headaches
- ❑ Cancer/chemotherapy
- ❑ Radiation treatments
- ❑ Psychiatric problems
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Difficulty breathing
- ❑ Hospitalized for any reason
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Thyroid disease
- ❑ Angina
- ❑ Artificial hip/joints
- ❑ Gout
- ❑ Chest pain
- ❑ Circulatory problems
- ❑ Cold sores
- ❑ Congenital heart lesion
- ❑ Cortisone medicine
- ❑ Convulsions
- ❑ Herpes
- ❑ Leukemia
- ❑ Excessive thirst
- ❑ Hay fever
- ❑ Heart disease
- ❑ Hives/skin rash
- ❑ Hypoglycemia
- ❑ Irregular heartbeat
- ❑ Lung disease
- ❑ Osteoporosis
- ❑ Pain in jaw joints
- ❑ Parathyroid disease
- ❑ Recent weight loss
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Sickle cell anemia
- ❑ Sinus trouble
- ❑ Tattoos/body piercing
- ❑ TMD/TMJ (jaw pain)
- ❑ X-ray or cobalt treatment
- ❑ Yellow jaundice
- ❑ Chronic fatigue syndrome
- ❑ Cough-persistent or bloody
- ❑ Latex sensitivity
- ❑ Smoker
- ❑ Swelling of feet/ankles
- ❑ Swollen neck glands
- ❑ Tonsillitis
- ❑ Tumor or growth on head/neck
- ❑ Easily winded
- ❑ Anaphylaxis
- ❑ Alzheimer's disease
- ❑ Frequent diarrhea
- ❑ Genital herpes
- ❑ Renal dialysis
- ❑ Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you take or have you taken Phen-Fen or Redux? ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Do you use alcohol, cocaine, or other drugs? ❍Yes ❍No

Do you wear contact lenses? ❍Yes ❍No

Are you on a special diet? ❍Yes ❍No

Have you lost or gained more than 10 pounds in the past year? ❍Yes ❍No

Do you use more than two pillows to sleep? ❍Yes ❍No

Have you ever had any excessive bleeding requiring special treatment? ❍Yes ❍No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? ❍Yes ❍No

Have you been treated in a hospital in the last five years? ❍Yes ❍No

If female, please mark if you are:
❏ Pregnant - If so, please enter your due date or week #:
❏ Trying to get pregnant ❏ Nursing ❏ On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? ❍Yes ❍No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:
Reviewed by: Title: Date: / /