Shorey Dentistry
Comprehensive Family Care

Patient Name_____ Birthdate_____

Cell # ( ) _____ Home # ( ) _____ Work # ( ) _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious illness or surgery? ☐ Yes ☐ No If yes, please explain _____

Have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken meds for Osteoporosis? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Please list any medications, pills or drugs you are taking: _____

WOMEN ONLY: Are you taking birth control? ☐Yes ☐No Are You Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Do You Have Allergies To Any Of The Following?

YES NO		YES NO		YES NO		YES NO	
☐☐	Aspirin	☐☐	Erythromycin	☐☐	Metals	☐☐	Other
☐☐	Codeine	☐☐	Jewelry	☐☐	Penicillin		_____
☐☐	Dental Anesthetic	☐☐	Latex	☐☐	Tetracycline		_____

Check Any Of The Following That Apply To Patient Health History:

Y N		Y N		Y N	
☐☐	Abnormal Bleeding	☐☐	Fainting Spells	☐☐	Pain in Jaw Joints
☐☐	Alcohol Abuse	☐☐	Fever Blisters	☐☐	Psychiatric Problems
☐☐	Alzheimer's	☐☐	Freq. Headaches	☐☐	Radiation Therapy
☐☐	Anemia	☐☐	Glaucoma	☐☐	Rheumatic Fever
☐☐	Angina Pectoris	☐☐	HIV+/AIDS	☐☐	Seizures
☐☐	Arthritis	☐☐	Heart Disease	☐☐	Shingles
☐☐	Artificial Heart Valve	☐☐	Heart Surgery	☐☐	Sickle Cell
☐☐	Asthma	☐☐	Hemophilia	☐☐	Sinus Problems
☐☐	Blood Transfusion	☐☐	Hepatitis A	☐☐	Stroke / TIA
☐☐	Cancer/Chemo	☐☐	Hepatitis B/C	☐☐	Thyroid Disease
☐☐	Colitis	☐☐	High Blood Pressure	☐☐	Tuberculosis
☐☐	Congenital Heart Disorder	☐☐	Joint Replacement	☐☐	Ulcers
☐☐	Diabetes	☐☐	Kidney Disease	☐☐	Venereal Disease
☐☐	Difficulty Breathing	☐☐	Liver Disease	☐☐	Yellow Jaundice
☐☐	Drug Abuse	☐☐	Low Blood Pressure	☐☐	Other_____
☐☐	Emphysema	☐☐	Mitral Valve Prolapse	☐☐	Other_____
☐☐	Epilepsy	☐☐	Pacemaker		

Do you have any disease, condition or problem not listed above? ☐Yes ☐No If yes, please explain _____

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_____

I understand the above information is necessary to provide the safest and most efficient dental care for me. I certify I have read and answered the above questions to the best of my knowledge. I will not hold my dentist or any member of the dental team/staff responsible for any errors or omissions that I have made in the completion of this form. I hereby agree to notify the dentist if any changes occur to my reported health status.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient/Guardian Signature_____**Date**_____

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