**MEDICAL HISTORY**

PHYSICIANS NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF LAST VISIT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently under medical treatment**? (YES/NO**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(WOMEN ONLY) ARE YOU: PREGNANT **(YES/NO)** NURSING **(YES/NO)** BIRTH CONTROL **(YES/NO)**

2. Have you ever had any serious illnesses or operations? (**YES/NO)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you currently taking any medications? (**YES/NO**) Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Do you smoke? **(YES/NO)**  Do you use alcohol? **(YES/NO)** Do you use drugs? (**YES/NO)**

5. Are you **ALLERGIC**  to or have you had any reactions to the following? (Local Anesthetics - **YES/NO**) (Penicillin or other antibiotics - **YES/NO**) (Sulfa Drugs - **YES/NO**) (Sedatives/Barbituates (Sleeping Pills) - **YES/NO**) (Aspirin - **YES/NO**) (Latex - **YES/NO**) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you taking or have you taken BISPHOSPHONATES (AVASTIN, PROLIA, XGEVA, FOSOMAX, ACTONEL, BONIVA, ATELVIA, DIDRONEL, SKELID, BONEFOS) **(YES/NO)**

**YES/NO** AIDS/HIV **YES/NO** CHRONIC FATIGUE SYNDROME **YES/NO** HEART MURMUR **YES/NO** MITRAL VALVE PROLAPSE

**YES/NO** ANEMIA **YES/NO** CIRCULATORY PROBLEMS **YES/NO** HEART PROBLEMS **YES/NO** PACEMAKER

**YES/NO** ASTHMA **YES/NO** HEPATITIS TYPE\_\_\_\_\_\_ **YES/NO** PSYCHIATRIC CARE **YES/NO** CONGENTIAL HEART LESIONS

**YES/NO** HERPES **YES/NO** CORTINSONE TREATMENTS **YES/NO** ARTIFICIAL JOINTS **YES/NO** SWOLLEN NECK/GLANDS

**YES/NO** ULCER **YES/NO** RADIATION TREATMENT **YES/NO** RESPIRATORY DISEASE **YES/NO** HIGH BLOOD PRESSURE

**YES/NO** CANCER **YES/NO** THYROID PROBLEMS **YES/NO** BACK PROBLEMS **YES/NO** DIABETES

**YES/NO** ARTHRITIS **YES/NO** RHEUMATIC FEVER **YES/NO** EMPHYSEMA **YES/NO** BLEEDING ABNORMALLY

**YES/NO** EPILEPSY **YES/NO** TUBERCULOSIS **YES/NO** SHORTNESS OF BREATH **YES/NO** FAINTING/DIZZINESS

**YES/NO** COUGH **YES/NO** SINUS TROUBLE **YES/NO** CHEMOTHERAPY **YES/NO** KIDNEY DISEASE

**YES/NO** GLAUCOMA **YES/NO** LOW BLOOD PRESSURE **YES/NO** LIVER DISEASE **YES/NO** CHEMICAL DEPENDENCY

**YES/NO** STROKE **YES/NO** HEADACHES **YES/NO** SCARLET FEVER **YES/NO** TUMOR/GROWTH (HEAD/NECK)

**ASSIGNMENT**

I hereby authorize payment directly to Crown Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or provider or supplier in this office to release information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. Any co pays due will be collected at time of service.

Signature of Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_