MEDICAL HISTORY

PHYSICIANS NAME:_____________________________________DATE OF LAST VISIT:__________________________

1. Are you currently under medical treatment?____

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

2. Have you ever had any serious illnesses or operations?____

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

____

4. Do you smoke? (YES/NO) Do you use alcohol? (YES/NO) Do you use caffeine or other drugs? (YES/NO)

5. ARE YOU **ALLERGIC** TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING? (circle all that apply)

Local Anesthetics (eg novocaine) Penicillin or other antibiotics Sulfa Drugs Iodine

Sedatives Barbiturates (Sleeping Pills) Aspirin Latex OTHER:____

Are you taking or have you taken BISPHOSPHONATES (AVASTIN, PROLIA, XGEVA, FOSOMAX, ACTONEL, BONIVA, ATELVIA, DIDRONEL, SKELID, BONEFOS)

PLEASE CIRCLE ALL THAT APPLY

AIDS/HIV	CHRONIC FATIGUE SYNDROME	HEART MURMUR	MITRAL VALVE PROLAPSE
ANEMIA	CIRCULATORY PROBLEMS	HEART PROBLEMS	PACEMAKER
ASTHMA	HEPATITIS TYPE______	PSYCHIATRIC CARE	CONGENTIAL HEART LESIONS
HERPES	CORTINSONE TREATMENTS	ARTIFICIAL JOINTS	SWOLLEN NECK/GLANDS
ULCER	RADIATION TREATMENT	RESPIRATORY DISEASE	HIGH BLOOD PRESSURE
CANCER	THYROID PROBLEMS	BACK PROBLEMS	DIABETES
ARTHRITIS	RHEUMATIC FEVER	EMPHYSEMA	BLEEDING ABNORMALLY
EPILEPSY	TUBERCULOSIS	SHORTNESS OF BREATH	FAINTING/DIZZINESS
KIDNEY DISEASE	SINUS TROUBLE	CHEMOTHERAPY	COUGH (PERSISTANT/BLOODY)
GLAUCOMA	LOW BLOOD PRESSURE	LIVER DISEASE	CHEMICAL DEPENDENCY
STROKE	HEADACHES	SCARLET FEVER	TUMOR OR 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.

Signature of Responsible Party:____ Date:__________________________