ADVANCED
DENTISTRY
General, Cosmetic & Sleep Solutions

Name ______________________________ Email ______________ Birthdate __________
Last Name First Name Initial

Address ______________________________ City ______________ State ______ Zip ________

Home #____________________ Work #____________________ Cell# ________________

Employer ______________________________ Occupation ____________________________________

Who may we thank for referring you? ____________________________________

If you carry Dental Insurance please provide your Insurance Card and Social Security Number ______________________________

Notify in case of emergency ____________________________ Phone# _________________ Relationship __________________

MEDICAL HISTORY

Have you ever had any of the following? (Circle all that apply)

Heart Murmur	Epilepsy	Rheumatic Fever	High/Low Blood Pressure	Hepatitis
Diabetes	Cancer/Chemotherapy	Sinus Problems	Asthma/Arthritis	Ulcers
Artificial Valves/Joints	Congenital Heart Defect	Radiation Treatment	Blood Transfusion	Anemia
Difficulty Breathing	Emphysema/Glaucoma	Heart Attack/Stroke	Heart Surgery/ Pacemaker	Hemophilia
HIV/AIDS	Kidney Problems	Shingles	Mitral Valve Prolapse	Oral Herpes
Severe/ Frequent Headaches		Hospitalized For Any Reason		

Do you have any drug ALLERGIES or have you ever had an adverse reaction to any medication? __________________________

Current Medications____

Physician's Name__________________________ Phone# ___________________ Date of Last Physical _______________

Are you currently under the care of a physician? __________ If so, why ____

(Women) Do you suspect that you are pregnant?_________ Nursing?__________

DENTAL HISTORY

Do you floss daily? __________ Brush daily? _________ Do your gums ever bleed? ________________________________
Decay Rate: Please circle. High Medium Low Periodontal (Gum) Surgery?______ Oral Cancer?_________
Wisdom Teeth out ____________ History of Orthodontics? ______When?____________# of times______Retainers?___________
History of extensive Dental Work?____
Bad Experience in Dental Office?____
Do you clench?_____________ Grind?___________ Wear a Mouth/Bite/Night Guard?______________________
Do you snore?______ Do you have Sleep Apnea?____ Do you wear a CPAP?_____ Have you ever had a Sleep Study?____
Are you interested in improving Athletic performance with a custom made mouth guard?_________________________

I understand that the above information will help Dr. Popp & Dr. Bailey determine appropriate and healthy dental treatment. If there is any change in my medical status, I will inform her. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date ____________________________