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	Ulcers
Artificial Valves/Joints	Congenital Heart Defect	Radiation Treatment	Arthritis	Anemia
Difficulty Breathing	Emphysema	Heart Attack/Stroke	Blood Transfusion	Hemophilia
HIV/AIDS	Glaucoma	Shingles	Heart Surgery/ Pacemaker	Oral Herpes
Severe/ Frequent Headaches	Kidney Problems	Hospitalized For Any Reason	Mitral Valve Prolapse	

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 _____