ADVANCED DENTISTRY

General, Cosmetic & Sleep Solutions

Name _____ Email _____ Birthdate _____

Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell# _____

Employer _____ Occupation _____

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				

Please explain any circled conditions from the above _____

_____

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

Current Medications_____

Hospitalized for any reason in the last 5 years? _____

Have you been told to take antibiotics before your dental appointments? _____

Physician's Name_____ Phone#_____ Date of Last Physical _____

(Women) Do you suspect that you are pregnant? _____ Nursing? _____

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_____