ADVANCED DENTISTRY

General, Cosmetic & Sleep Solutions

Name _____ Email _____ Birthdate _____

Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Best Number to reach you #_____

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_____

Chief complaint or concern for today's appointment _____

_____

For Emergency Visits only (it is not necessary to fill out if this is only for a consultation)

What is your pain level on a scale of 1-10? _____

How long has the pain been going on? _____

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_____

☐ I allow Advanced Dentistry to use my cell phone number to receive text messages regarding my dental appointments. I understand my phone number will not be shared outside of the office, that message frequency may vary, that I will be able to opt out of messages and that message and data rates may apply.