



# ADVANCED DENTISTRY

General, Cosmetic & Sleep Solutions

Name \_\_\_\_\_ Email \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Last Name First Name Initial

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)

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

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? \_\_\_\_\_

Are you taking or have you taken any of the following in the last 3 months?

Y/N - Bisphosphonates Y/N - Birth Control Pills Y/N - Tobacco Products Y/N - Anti-Depressants Y/N - Opioids NONE

Current Medications \_\_\_\_\_

Hospitalized for any reason in the last 5 years? \_\_\_\_\_

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

Have you ever had a bad reaction to dental anesthetic? \_\_\_\_\_

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 \_\_\_\_\_

- ☐ 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