

**Advanced Dental Center**  
**Dr. Bill Burgess ~ Dr. Louis Burgess**  
**8159 Walnut Grove Road Cordova, TN 38018**  
**Tel: 901.756.8111 Fax: 901.756.8171 burgessdental.net**  
New Patient Registration Form

**WELCOME**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SEX (M/F) \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

WHICH # DO YOU PREFER TO BE CALLED ON DURING DAYTIME HOURS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

NAME OF RESPONSIBLE PARTY & ADDRESS (IF DIFFERENT) \_\_\_\_\_

SPOUSES NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

SPOUSES EMPLOYER \_\_\_\_\_ SPOUSES SOCIAL SECURITY # \_\_\_\_\_

DENTAL INS. (Y/N) \_\_\_\_\_ POLICY HOLDER'S NAME \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

DATE OF LAST DENTAL EXAM \_\_\_\_\_ FORMER DENTIST \_\_\_\_\_

E-MAIL \_\_\_\_\_

**MEDICAL HISTORY**

**YES NO**

- \_\_\_\_ 1. Are you in good general health at this time?
- \_\_\_\_ 2. Have you been hospitalized in the last 5 years? Reason \_\_\_\_\_
- \_\_\_\_ 3. Do you have or have you ever had anemia?
- \_\_\_\_ 4. Do you have or have you ever had diabetes?
- \_\_\_\_ 5. Do you have or have you ever had epilepsy?
- \_\_\_\_ 6. Do you have or have you ever had hepatitis?
- \_\_\_\_ 7. Do you have or have you ever had rheumatic fever?
- \_\_\_\_ 8. Do you have an abnormal heart condition?
- \_\_\_\_ 9. Do you have abnormal bleeding from a cut?
- \_\_\_\_ 10. Do you smoke or use smokeless tobacco?  
If yes, how much/how often? \_\_\_\_\_
- \_\_\_\_ 11. Are you allergic to local anesthetic?
- \_\_\_\_ 12. Are you allergic to penicillin or any other medication?\*
- \_\_\_\_ 13. Are you taking any medications at this time?\*\*\*
- \_\_\_\_ 14. Are you allergic to latex?
- \_\_\_\_ 15. Have you had an artificial joint placed within the last 2 years?
- \_\_\_\_ 16. Women: Are you pregnant or nursing?
- \_\_\_\_ 17. Do you have abnormal blood pressure? High \_\_\_\_\_ Low \_\_\_\_\_
- \_\_\_\_ 18. Do you take a blood thinner or aspirin?
- \_\_\_\_ 19. Have you been tested for HIV? \_\_\_positive \_\_\_negative

Are you pleased with the appearance of your teeth? \_\_\_\_ Yes \_\_\_\_ No  
If not, then why? \_\_\_\_\_

Are you interested in sedation dentistry for your dental treatment? \_\_\_\_ Yes \_\_\_\_ No

\*List medications you are allergic to: \_\_\_\_\_

\*\*List medications you are presently taking: \_\_\_\_\_