

WALNUT GROVE WOODS DENTAL OFFICE

**Dr. Bill Burgess
Dr. Louis Burgess
8159 Walnut Grove Road
Cordova, TN 38018**

PERSONAL HISTORY UPDATE

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 _____

DENTAL INS. (Y/N) _____

INSURANCE UPDATE*COMPLETE IF CHANGES TO INSURANCE SINCE LAST APPT*****

NAME OF INSURANCE COMPANY _____

POLICY HOLDER'S NAME (IF OTHER THAN SELF) _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S SS# _____ POLICY ID # _____

GROUP # _____

MEDICAL HISTORY UPDATE

YES NO

- ____ ____ 1. Are you in good general health at this time?
- ____ ____ 2. Have you been hospitalized in the last 5 years?
- ____ ____ 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?
- ____ ____ 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 _____