

WALNUT GROVE WOODS DENTAL OFFICE
Dr. Bill Burgess
Dr. Louis Burgess
8159 Walnut Grove Road
Cordova, TN 38018

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 _____ SOCIAL SECURITY # _____
DENTAL INS. (Y/N) _____ NAME OF INSURANCE COMPANY _____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____
DATE OF LAST DENTAL EXAM _____ FORMER DENTIST _____

MEDICAL HISTORY

- | 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 _____

