

SHAWN A. WALLS, D.D.S
10700 Medlock Bridge Road
Suite 202
Johns Creek, GA 30097
(770) 813-0079

Date: _____

PATIENT INFORMATION

Name: _____ Home Phone: _____
Last Name First Name Initial

Address: _____
Street City State Zip Code

Alternate Phone Number: _____ EMAIL: _____

Sex: M F Age: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Phone: _____ Occupation: _____

Business Address: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ Relationship to Patient: _____

Home Address (If different from patient): _____ Phone: _____

Employer: _____ Phone: _____ Occupation: _____

Insurance Company: _____ Address: _____

Group #: _____ Birth Date: _____ SSN: _____ Ins. Co. Phone #: _____

Name of any other dependents covered under this plan: _____

DENTAL HISTORY

Reason for present visit: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Former Dentist: _____ Address: _____ Phone: _____

Are you experiencing any of the following?

Bleeding Gums	Loose teeth	Sensitivity to sweets	Clicking or popping jaw
Broken teeth or fillings	Sensitivity when biting	Food collection b/t teeth	Wear on front teeth
Discolored fillings or teeth	Sensitivity to cold or hot	Habit of grinding/clenching	Sores or growths
Periodontal treatment			Dry mouth

How often do you brush? _____ Floss? _____ Any other oral hygiene aids you may use: _____

Is there anything we should know about your past experiences in a dental office? _____

Anything which will make you more comfortable during treatment? _____

OVER.....

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? If yes, please describe: _____

Have you ever had a blood transfusion? Yes No If yes, please give approximate date(s): _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Circle if you have or have had any of the following:

- | | | | |
|---------------------------|----------------------|-----------------------|----------------------------|
| AIDS | Cortisone Treatments | Hepatitis | Rhuematic Fever |
| Anemia | Cough, persistant | High Blood Pressure | Scarlet Fever |
| Arthritis, Rheumatism | Cough up blood | HIV Positive | Shortness of breath |
| Artificial Heart Valve(s) | Diabetes | Jaw Pain | Skin Rash |
| Artificial Joint(s) | Epilepsy | Kidney Disease | Stroke |
| Asthma | Fainting | Liver Disease | Swelling of feet or ankles |
| Back Problems | Glaucoma | Mitral Valve Prolapse | Thyroid Problems |
| Blood Disease | Headaches | Nervous Problem | Tobacco Habit |
| Cancer | Heart Murmur | Pacemaker | Tonsillitis |
| Chemical Dependency | Heart Problems | Psychiatric Care | Tuberculosis |
| Chemotherapy | Describe _____ | Radiation Treatment | Ulcer |
| Circulatory Problems | Hemophillia | Respiratory Disease | Venereal Disease |

MEDICATIONS

List medications you are currently taking: _____ Pharmacy Name: _____
_____ Phone Number: _____

Any vitamins, herbal supplements or "cures" (example Phen-Phen)? _____

ALLERGIES

Aspirin	Barbiturates (Sleeping pills)	Codeine	Local Anesthetic
Penicillin	Sulfa	Other _____	

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____