Carl W. Schulter, DDS, FACP Darren R. Williams, DDS
Amir V. Francis, DDS Elizabeth Felton, DDS
795 Ridge Lake Boulevard Ste. 101
Memphis, TN 38120
901-682-5001

Patient's Name _____ Date _____

Address _____ City, State, Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's DOB _____ ☐ Male ☐ Female ☐ Single ☐ Married

Social Security Number _____ Person Responsible for Payment _____

Patient's Physician _____ Physician's Telephone _____

Physician's Address (if known) _____

Patient's Dentist _____ Dentist's Telephone _____

Dentist's Address (if known) _____

Who may we thank for referring you to our office? _____

Reason for today's visit _____

Email Address _____

INSURANCE INFORMATION

Subscriber's Name _____ DOB _____ SS# _____

Subscriber's Address _____ City, State, Zip Code _____

Employer _____

Primary Dental Insurance Company _____

Insurance ID _____ Group # _____

PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Telephone _____

Pharmacy Address _____

I hereby authorize Dental Implant Aesthetic Center to recieve payments of any insurance benefits, otherwise payable to me under the terms of my insurance, for services rendered.

X _____ _____
Signature (patient or parent/guardian if minor child) Date

MEDICAL HISTORY

Patient's Name _____ Age _____ Date _____

Do you have or have you ever had any of the following conditions?

	Y	N		Y	N
Abnormal Bleeding	☐	☐	Asthma/Breathing Problems	☐	☐
AIDS/HIV	☐	☐	Blood Disease	☐	☐
Alcohol or Drug Abuse	☐	☐	Cancer	☐	☐
Anemia	☐	☐	Circulatory Problems	☐	☐
Artificial Heart Valve	☐	☐	Diabetes	☐	☐
Artificial Joint	☐	☐	Epilepsy	☐	☐
Excessive Bleeding	☐	☐	Facial Pain	☐	☐
Frequent Headaches	☐	☐	Glaucoma	☐	☐
Have you ever had Cortizone	☐	☐	Heart Attack	☐	☐
Heart Disease	☐	☐	Heart Surgery	☐	☐
Hepatitis Type	☐	☐	High Blood Pressure	☐	☐
Liver Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐
Radiation Therapy	☐	☐	Rheumatic Fever	☐	☐
Seizure Disorder	☐	☐	Shingles	☐	☐
TB	☐	☐	Sinus Problems	☐	☐
Thyroid Problems	☐	☐	Persistent Cough	☐	☐
Smoke/Use Tobacco	☐	☐	Height _____ Weight _____		

Is there any other disease, condition or problem that you think this office should be aware of that is not mentioned above? If yes, please describe below.

_____

If female please answer the following questions:

Are you pregnant or is there any chance you may be pregnant? If yes , how many weeks? _____

Are you nursing? ☐ Yes ☐ No Are you using oral contraceptives/contraceptive patch? _____

All patients please answer the following questions:

Please list all known drug allergies _____

Please list all known food allergies _____

Please list all medications you are currently taking _____

_____

_____

X _____ _____

Signature (patient or parent/guardian if minor child) Date