



Carl W. Schulter, DDS, FACP 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 receive 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.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Breathing Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Drug Abuse.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Facial Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Cortizone.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis Type.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints.....	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>
TB.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Smoke/Use Tobacco.....	<input type="checkbox"/>	<input type="checkbox"/>	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