DAVID W. EDWARDS, D.M.D.

Specializing in Mercury-Free Dentistry
General, Cosmetic, Family

Thank you for scheduling your problem focused exam appointment.

Please complete your new patient information. If possible, please fax to 407.330.0953 or email to info@holisticdentalhealth.com prior to your appointment. You may also bring it to your appointment.

Your appointment will consist of a problem focus evaluation of **one area of concern** and probable radiograph. The cost of this appointment averages $120. and you should plan on spending approximately 30 – 60 minutes with us. Treatment fees will be quoted at that time.

Within 3 months we require you have a thorough exam with our office. We do not see patients on an emergency-only basis. If you do not come for a thorough exam within 3 months, you will be considered inactive.

Your thorough exam will consist of a comprehensive oral evaluation, soft/hard tissue charting (including previous dental restorations, current decay, fractures, etc) a digital panoramic radiograph, digital bitewing radiographs, digital photographs and complete treatment planning. The cost of this appointment averages $398. and you should plan on spending approximately 2 hours with us.

If you have had *digital* radiographs taken within 1 year; please ask the office to email them to info@holisticdentalhealth.com along with the date they were taken. We prefer the radiographs be emailed since the diagnostic value is much greater.

We are a fee-for-service dental practice, which means we do not accept assignment of insurance benefits. If you have dental insurance, you will be responsible for paying for your visit in full and we will happily print the claim form for you to submit to your insurance company so they can reimburse you directly. Please confirm your insurance has out-of-network benefits and provide us with all pertinent information (page 9). We are not an insurance provider and do not know what your insurance will reimburse. You are responsible for verifying your benefits.

Due to the nature of our practice, we have many patients that are chemically sensitive. ***We kindly request that you refrain from wearing any fragrances.***

Thank you for choosing our office for your dental needs. We look forward to meeting you.

Respectfully,

Ja'

Ja'Monique Long

541 N. Palmetto Avenue Suite 101 Sanford, Florida 32771
Phone (407) 322-6143 * FAX (407) 330-0953 * www.HolisticDentalHealth.com

George W. Edwards, D.M.D. David W. Edwards, D.M.D.

541 N. Palmetto Avenue, Suite 101
Sanford, FL 32771
407-322-6143

Thank you for selecting our dental healthcare team to serve your dental needs. We shall endeavor to provide you with quality dental healthcare. Our office is committed to meeting shared expectations for excellence in health. Please help us by filling out this form and adding any additional information you feel important to share. We want to answer any questions you may have now or have at any time during your treatment.

Today's Date: _____

Is this form being completed for a child? ☐ No ☐ Yes (Please complete a separate form for each child)

Patient Information: Miss_____ Ms_____ Mrs_____ Dr_____ Mr_____

_____ _____
Last Name First MI Date of Birth

Male____ Female____ Marital Status: Single____ Married____ Divorced____ Widowed____ Separated_____

_____
Street Address City State Zip Code

_____
Home Phone Cell Phone Best Daytime Number

E-Mail Address:_____ Ok to send office information? ☐ Yes ☐ No

Additional Information (Patient & Spouse **OR** Parents for Child)

_____
Patient Occupation Employer Name How Long?

_____
Employer Address City State Zip Code Phone Number

Spouse Name: _____

_____
Spouse Occupation Spouse's Employer Name How Long?

_____
Employer Address City State Zip Code Phone Number

Dependent Children/Siblings:

Name/Age_____ Name/Age_____

Name/Age_____ Name/Age_____

Person Responsible for Account:_____ Relation:_____

SS #_____ DL # /State_____ Employer:_____

Home#:_____Work #:_____ Cell#:_____

Billing Address:_____

Street Address City State Zip Code

Emergency Contact: _____ Relation: _____

Home#:_____Work #:_____ Cell#:_____

Primary Physician's Name:_____

_____

Address City State Zip Code Phone #

_____

Secondary Physician/Health Care Provider's Name Physician's Specialty

_____

Address City State Zip Code Phone #

Other health care providers (nutritionists, physical therapists, etc)_____

_____

How did you hear about our office? *May we contact them with a "Thank You"?* ☐ *yes* ☐ *no*

Name: _____Relationship: _____

Address/Phone #: _____

1. What is your reason(s) for being here? _____

_____

2. Is there anything or anyone preventing you from seeking appropriate medical/dental care? _____

_____

3. Last dental visit and reason for visit: _____

_____

4. **Dental History** (check all previous services received in dental facilities):

- ☐ Dental exam with x-rays, Date:_____
- ☐ Periodontal (gum) Treatment
- ☐ Restorations (fillings)
- ☐ Crown & Bridgework (fixed)
- ☐ Tooth extraction or oral surgery
- ☐ Endodontic (root canal) Treatment
- ☐ Complete Dentures
- ☐ Partial Dentures (removable)
- ☐ Orthodontic (braces) Treatment
- ☐ Special Diagnostic Exam

Explain:_____

_____

5. **Previous Dental Experiences**:

- ☐ Pleased with previous dental experience(s)
- ☐ Unpleasant previous dental experience (describe): _____

_____

6. **Self Analysis of Oral Tissue Health** (check any problems that you have):

- ☐ Bad breath
- ☐ Crooked Teeth
- ☐ Bad Bite/Bite feels off
- ☐ Teeth painful to hot, cold or sweets
- ☐ Swelling in mouth or jaws on occasion
- ☐ Food catching between teeth
- ☐ Severe Toothaches
- ☐ Cavities
- ☐ Dry Mouth
- ☐ Frequent sores on mouth/lips
- ☐ Bleeding gums
- ☐ Loose or drifting teeth
- ☐ Bad taste in mouth
- ☐ Other problems (describe):_____

_____

7. **Attitudes about Dental Health Care**

Y	N	
☐	☐	Most people will eventually lose their teeth
☐	☐	Good dental care can prevent tooth loss
☐	☐	Do you only see the dentist for emergency care?
☐	☐	Do you brush every day?
☐	☐	Do you floss every day?

8. **Oral Habits**

Y	N		
☐	☐	Do you or have you ever smoked cigarettes?	_____packs per day for _____ years
☐	☐	Do you chew tobacco or use snuff?	_____ times per day for _____ years
☐	☐	Do you drink alcohol?	_____ times per day or _____ week
☐	☐	Do you chew gum?	_____ sticks per day ____sugar free
☐	☐	Do you drink sugary drinks frequently?	_____ times per day or _____ week

9. **Health History**

	Y	N		
CARDIOVASCULAR	☐	☐	Have you ever been told you have heart trouble?	
	☐	☐	Have you ever been told you have ___high or___low blood pressure?	
	☐	☐	Do you get out of breath easily?	
	☐	☐	Have you ever had rheumatic fever?	
	☐	☐	Do you have a heart murmur as a consequence of rheumatic fever?	
	☐	☐	Do you have a prolapsed mitral valve?	
	☐	☐	Have you ever been told you have a heart murmur of any cause?	
	☐	☐	Have you ever been told to take antibiotics before dental treatment?	
	☐	☐	Have you had a heart attack?	
	☐	☐	Have you had a stroke?	
	☐	☐	Do your ankles become swollen easily?	
	☐	☐	Do you suffer from angina pectoris (chest & left arm pain)?	
SENSES	☐	☐	Have you had earaches or other ear problems?	
	☐	☐	Have you had eye problems such as glaucoma or other problems?	
	☐	☐	Have you noticed any changes in your sense of smell or taste?	
	☐	☐	Have you had bad breath (halitosis)?	

RESPIRATORY	Y N ☐ ☐ Do you have the flu or a cold more than twice a year? ☐ ☐ Do you have asthma, hay fever, sinusitis or frequent sore throats? ☐ ☐ Have you had pneumonia or a lung infection? ☐ ☐ Do you have, or have you been exposed to, tuberculosis? ☐ ☐ Do you have a chronic cough or cough up blood? ☐ ☐ Do you have bronchitis or emphysema?	
NEUROLOGIC	Y N ☐ ☐ Have you ever been under psychiatric care or had counseling? ☐ ☐ Do you have numbness or tingling feelings anywhere? ☐ ☐ Have you ever had a nervous breakdown? ☐ ☐ Are you anxious or depressed frequently? ☐ ☐ Do you have epilepsy, seizures, or other neurologic disorders?	
ENDOCRINE	Y N ☐ ☐ Do you have diabetes? ☐ ☐ Does any member of your family have diabetes? ☐ ☐ Are you thirsty frequently or urinate frequently? ☐ ☐ Do you have thyroid problems or take thyroid medication? ☐ ☐ Do you have any other gland problems?	
GI	Y N ☐ ☐ Have you had jaundice, liver trouble or hepatitis? ☐ ☐ Do you have stomach problems or ulcers? ☐ ☐ Do you have frequent or prolonged diarrhea or constipation? ☐ ☐ Do you have frequent episodes of acid reflux or vomiting? ☐ ☐ Has your weight changed more than 20 pounds in the past year?	
GU	Y N ☐ ☐ Have you ever been told you have kidney or bladder trouble? ☐ ☐ Have you had any sexually transmitted diseases (syphilis, gonorrhea, genital herpes, HIV infection AIDS)? ☐ ☐ Have you had any reproductive tract problems?	
HEMATOLOGY	Y N ☐ ☐ Have you had anemia? ☐ ☐ Do you have leukemia? ☐ ☐ Do you bruise or bleed easily?	
IMMUNOLOGY	Y N ☐ ☐ Are you sensitive or allergic to any medications? (Penicillin, sulfa drugs, aspirin, etc.) **Please list on page 7** ☐ ☐ Are you allergic to any foods, metals, pollens or latex (rubber)? ☐ ☐ Have you been treated for a skin disease? ☐ ☐ Do you have a defective immune system? ☐ ☐ Do you take medications that suppress your immune system?	

MUSCLE SKEL	Y N ☐ ☐ Are your joints often painfully swollen or do you have arthritis? ☐ ☐ Do you have back problems? ☐ ☐ Have you had more than one fracture or dislocation? ☐ ☐ Do you have osteoporosis?	
SURGERY - ANESTHESIA	Y N ☐ ☐ Have you had an operation? ☐ ☐ Have you had a series of shots or injections? ☐ ☐ Have you ever had anesthesia? ☐ Local ☐ General ☐ ☐ Have you ever been told not to take Novocaine or other medication? ☐ ☐ Have you ever been told you have cancer or a tumor? ☐ ☐ Have you ever had chemotherapy? ☐ ☐ Have you ever had radiation therapy? ☐ ☐ Have you ever had an organ or bone marrow transplant? ☐ ☐ Are you using any recreational drugs or substances? ☐ ☐ Are you an active or recovering substance abuser?	
IMPLANTS	Y N ☐ ☐ Do you have a prosthetic (artificial) heart valve? ☐ ☐ Do you have a pacemaker or defibrillator? ☐ ☐ Have you had vascular or cardiac repair with synthetic materials? ☐ ☐ Do you have a vascular shunt (hem dialysis or drug therapy)? ☐ ☐ Do you have any prosthetic joints (hip, knee, ankle, shoulder)? ☐ ☐ Do you have any other implants?	
FACIAL PAIN	Y N ☐ ☐ Do you have a history of head or neck injury? ☐ ☐ Have you ever had severe pains of the face or head? ☐ ☐ Do you suffer from headache, eye pain or migraine? ☐ ☐ Do you have ear pain or pain in front of your ears? ☐ ☐ Does anything hurt when you chew? ☐ ☐ Does your jaw make noise that bothers you or others? ☐ ☐ Does the pain or discomfort interfere with your work activities?	
WOMEN	For Women Only: Y N ☐ ☐ Are you taking birth control pills or have Norplant? ☐ ☐ Are you pregnant? Expected delivery date: _____ ☐ ☐ Are you breast feeding?	

Are you being treated for any condition at this time? (Describe) _____

_____

Please list all medications, herbs and/or supplements you are taking at this time:

Med Herb Supp	Name of Medicine/Herb/Supplement	Reason For Taking
☐ ☐ ☐	_____	_____
☐ ☐ ☐	_____	_____
☐ ☐ ☐	_____	_____
☐ ☐ ☐	_____	_____
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☐ ☐ ☐	_____	_____
☐ ☐ ☐	_____	_____
☐ ☐ ☐	_____	_____

Please list all allergies and/or sensitivities: If no known allergies, please circle NONE

_____ _____

_____ _____

_____ _____

_____ _____

George W. Edwards, D.M.D. David W. Edwards, D.M.D.

I ☐ give (☐ do not give) the office of George W. Edwards, D.M.D., P.A. permission to use my photographs/radiographs for patient education and advertising.

I give permission to discuss my treatment/appointments/etc with the following family members, friends, and/or doctors:

PLEASE MAKE SURE TO ADD YOUR HEALTH CARE PRACTITIONERS

1._____ _____ _____
Name Relationship Phone #

2._____ _____ _____
Name Relationship Phone #

3._____ _____ _____
Name Relationship Phone #

4._____ _____ _____
Name Relationship Phone #

I affirm that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my data.

Patient/Guardian Signature:_____ Date:_____

Please Do Not Write Below This Line

Overall health _____

When was the patient's last physical exam by a Physician? _____

Physician's Name(s) _____

Address(es) _____

Phone(s) _____

Any additional information? _____

_____

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DAVID W. EDWARDS, D.M.D.

HOLISTIC AND COSMETIC FAMILY DENTISTRY

INSURANCE INQUIRY

Dr. Edwards is an "out-of-network" insurance provider. We do NOT accept insurance payments. Our office will provide you with a completed claim form for each visit. You will be responsible for keeping a copy & sending the form to your insurance company. There may be a charge associated with reprocessing lost insurance claim forms. We're happy to help you understand your insurance explanation of benefits.

THIS COMPLETED FORM IS REQUIRED FOR INSURANCE REIMBURSEMENT

Do you have "out-of-network" benefits? _____ Yes _____ No

If yes, complete the following. If no, you can not receive reimbursement.

Date: _____

Name of Insured: _____

Date of Birth: _____

Social Security Number: _____

Name of Employer or Self-Insured: _____

Relationship to Insured: _____

Name of Insurance Company: _____

Insurance Telephone #: _____

Fax Submission #: _____

Claim mailing address: _____

_____

Member ID #: _____

Group #: _____

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