

## DAVID W. EDWARDS, D.M.D.

Specializing in Mercury-Free Dentistry  
General, Cosmetic, Family

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Thank you for scheduling an appointment for your child.

Please complete your child's new patient information. If possible, please fax to 407.330.0953 or email to [info@holisticdentalhealth.com](mailto:info@holisticdentalhealth.com) prior to their appointment. You may also bring it to their appointment.

This appointment will consist of an initial hygiene/cleaning, periodontal assessment, an exam with Dr. Edwards and possible bitewing radiographs. The cost of this appointment averages \$185.-250. and you should plan on spending approximately 1- 1½ hours with us. Currently, periodic hygiene appointments after their new patient exam are \$130.

**If your child has had *digital* radiographs taken within 1 year; please ask the office to email them to [info@holisticdentalhealth.com](mailto: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 your insurance claim form for you to file with your insurance company to reimburse you directly. Please confirm your insurance has out-of-network benefits and provide us with all pertinent information. We are not an insurance provider and do not know what your insurance will reimburse. You are responsible for verifying your benefits. We are happy to file pre-treatment estimates for future treatment.*

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 soon.

Respectfully,



Ja'Monique Long  
Office Manager

# David W. Edwards, D.M.D.

Today's Date: \_\_\_\_\_

## New Patient Information for a Child

**Patient Information:** Male \_\_\_ Female \_\_\_ Name of School \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name MI Date of Birth

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Home Phone Cell Phone Best Daytime Number

E-Mail Address: \_\_\_\_\_ Ok to send office information?  Yes  No

**Parent Information:** Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Mother's Name: \_\_\_\_\_

\_\_\_\_\_  
Mother's Occupation Employer Name How Long?

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

Father's Name: \_\_\_\_\_

\_\_\_\_\_  
Father's Occupation Employer Name How Long?

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

### **Siblings:**

Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_

Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_

# David W. Edwards, D.M.D.

**Person Responsible for Account:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

SS # \_\_\_\_\_ DL # /State \_\_\_\_\_ Employer: \_\_\_\_\_

Home#: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street Address City State Zip Code

## Emergency Contacts:

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home#: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home#: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

**1. Primary Physician's Name:** \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code Phone #

**2.** \_\_\_\_\_

**Additional Physician/Health Care Provider's Name** Physician's Specialty

\_\_\_\_\_  
Address City State Zip Code Phone #

**3.** \_\_\_\_\_

**Additional Physician/Health Care Provider's Name** Physician's Specialty

\_\_\_\_\_  
Address City State Zip Code Phone #

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone #: \_\_\_\_\_

# David W. Edwards, D.M.D.

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):

- |   |  |
|---|--|
| <input type="checkbox"/> Dental exam with x-rays, Date: _____ | <input type="checkbox"/> Endodontic (root canal) Treatment |
| <input type="checkbox"/> Periodontal (gum) Treatment          | <input type="checkbox"/> Complete Dentures                 |
| <input type="checkbox"/> Restorations (fillings)              | <input type="checkbox"/> Partial Dentures (removable)      |
| <input type="checkbox"/> Crown & Bridgework (fixed)           | <input type="checkbox"/> Orthodontic (braces) Treatment    |
| <input type="checkbox"/> Tooth extraction or oral surgery     | <input type="checkbox"/> 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):

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

\_\_\_\_\_

# David W. Edwards, D.M.D.

## 7. Attitudes about Dental Health Care

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Y                        | N                        |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Most people will eventually lose their teeth    |
| <input type="checkbox"/> | <input type="checkbox"/> | Good dental care can prevent tooth loss         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you only see the dentist for emergency care? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you brush every day?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you floss every day?                         |

## 8. Oral Habits

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Y                        | N                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or have you ever smoked cigarettes? _____ packs per day for _____ years |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you chew tobacco or use snuff? _____ times per day for _____ years          |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? _____ times per day or _____ week                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you chew gum? _____ sticks per day _____ sugar free                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink sugary drinks frequently? _____ times per day or _____ week       |

## 9. Health History

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

## David W. Edwards, D.M.D.

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

## David W. Edwards, D.M.D.

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

# David W. Edwards, D.M.D.

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please list all allergies and/or sensitivities:

_____	_____
_____	_____
_____	_____
_____	_____



# David W. Edwards, D.M.D.

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

From time to time, we find it necessary to speak with family members or caregivers (Including Therapists and Doctors) regarding treatment and appointments. **HIPAA requires we have your permission.**

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

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.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# David W. Edwards, D.M.D.

## Insurance Information:

Name of Dental Insurance Company: \_\_\_\_\_

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

If the answer is "Yes" to the previous question, please continue with the remainder of the form. If the answer is "No", the remaining information is not necessary since we are an "out-of-network" provider.

**Information on insured is for the person carrying the insurance, not the dependent.  
This may or may not be the patient**

Name of Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Name of Employer or Self-Insured: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Insurance Company Telephone #: \_\_\_\_\_

Fax Submission #: \_\_\_\_\_

Claim mailing address: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_