DAVID W. EDWARDS, D.M.D.

Specializing in Mercury-Free Dentistry
General, Cosmetic, Family

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 e-mail to info@HolisticDentalHealth.com prior to their appointment. You may also bring it to their appointment.

This appointment will consist of a hygiene/cleaning, periodontal assessment, an exam with Dr. Edwards and possible bitewing radiographs. The cost of this appointment averages $263-356 and you should plan on spending approximately 1- 1½ hours with us. Currently, periodic hygiene appointments after their new patient exam are $187.

If your child has 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. **Images must be sent as individual digital .jpeg images, not formatted in a group. Images must be received in our office prior to their appointment day/time or new images must be taken.**

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' Long
Office Manager

541 N. Palmetto Avenue, Suite 101 * Sanford, Florida 32771
407.322.6143 * Fax 407.330.0953 * www.HolisticDentalHealth.com

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 Info: Marital Status: Single_____ Married _____ Separated _____ Divorced _____

Parent's Name: _____

_____

Occupation Employer Name How Long?

_____

Home Phone Work Phone Cell Phone

Parent's Name: _____

_____

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):

- ☐ 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):_____

_____

David W. Edwards, D.M.D.

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)?	

David W. Edwards, D.M.D.

RESPIRATORY	Y N ☐ ☐ Have you ever been diagnosed with a sleep disorder? ☐ ☐ If so, was treatment recommended? ☐ ☐ 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 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?	

David W. Edwards, D.M.D.

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?	

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
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____
☐	☐	☐	_____	_____

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:_____

David W. Edwards, D.M.D.

Dr. Edwards is "Out of Network" for ALL insurance.

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 #: _____

Revised 11.11.20

Office Policies

____ You are welcome to contact us by phone, text or email. Our phone number for texing & calling is 407.322.6143. Our e-mail is info@HolisticDentalHealth.com.

____ Our office is open Monday-Thursday 7am-3pm (we do not close for lunch).

____ We are not open for the following Holidays: Jan 1st, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Eve thru Jan 2nd (or first business day after).

____ Please confirm your appointments through our automated system. It is easy to use. You can confirm through text by replying "YES" for confirmed or clicking on the link in the confirming e-mail. We will make a personal call to you only if the automated system fails to confirm your appointment.

____ You may opt out of our automated system but then we ask that you be responsible for confirming your appointment.

____ If we are unable to confirm your appointment with you by noon the day before your appointment, your appointment will be cancelled.

____ If you wish to make any changes to your scheduled treatment, please contact us to discuss those changes at least 2 business days prior to your appointment.

____ We ask for 2 business days notice to reschedule/cancel your appointment. For example: Please contact us on Wed for an appointment on the following Mon.

____ After 3 failed/cancelled without notice appointments, we will ask that you pay for your appointment in advance.

____ We care about you, your teeth and your overall health. In order for us to take proper care of you, you must have at least one hygiene/cleaning appointment (with images) a year in our office to remain a patient.

____ **We do not see patients on an as-needed/emergency-only basis.**

____ Adult digital dental imaging schedule is a panoramic radiograph every 5 years and bitewing radiographs once a year (unless an issue arises sooner).

Thank you for your kind consideration.

Please read and initial each policy above, then sign that you have read our policies and agree.

_____ _____

Patient/Guardian Signature Date

_____

Printed Name

Revised 08.23.2023