

Holistic Dental Health

Specializing in Mercury-Free Dentistry
General, Cosmetic, Family

Thank you for scheduling an appointment for your child.

Attached are **editable** patient information forms to complete for your child's appointment. If possible, please email (info@HolisticDentalHealth.com) them back to our office prior to their appointment.

This appointment will consist of a hygiene/cleaning with one of our hygienists, periodontal assessment, a thorough exam with Dr. Edwards and bitewing radiographs. The cost of this appointment averages \$277-375 and you should plan on spending approximately 1- 1½ hours with us. Currently, periodic hygiene appointments after their new patient exam are \$197.

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 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.

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 child's dental needs. We look forward to meeting you soon.

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
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Street Address	City	State	Zip Code
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Home Phone	Cell Phone	Best Daytime Number
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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?
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Home Phone	Work Phone	Cell Phone
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Parent's Name: _____

Occupation	Employer Name	How Long?
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Home Phone	Work Phone	Cell Phone
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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:**

<input type="checkbox"/> Pleased with previous dental experience(s)	
<input type="checkbox"/> 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):	_____

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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?

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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

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?	
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)?	

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

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MUSCLE SKEL	<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>	
SURGERY - ANESTHESIA	<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>	
IMPLANTS	<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>	
FACIAL PAIN	<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>	
WOMEN	<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:

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 #: _____

Office Policies

- ____ You are welcome to contact us by phone, text or email. Our phone number for texting & 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

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