

Holistic Dental Health

Specializing in Mercury-Free Dentistry
General, Cosmetic, Family

Thank you for scheduling your problem focused exam appointment.

Please complete your **editable** patient information forms for your appointment. If possible, please email them back to our office prior 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 is \$183 and you should plan on spending approximately 30 – 60 minutes with us. Treatment fees will be quoted at that time.

*To become a patient, we require 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. We will be unable to see you for a 2nd emergency appointment if you have not had a thorough exam.*

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 \$596 and you should plan on spending approximately 2-3 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 require the radiographs be emailed since the diagnostic value is much greater.

Images must be sent as individual digital .jpeg images, not formatted in a group. Images must be received in our office prior to your 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 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. 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.

David W. Edwards, D.M.D.

Today's Date: _____

Patient Information:

Miss _____ Ms _____ Mrs _____ Dr _____ Mr _____

Last Name First Name 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 Occupation Employer Name How Long?

Employer Address City State Zip Code Phone Number

SS # _____ DL # /State _____

Spouse Name: _____

Spouse Occupation Spouse's Employer Name How Long?

Employer Address City State Zip Code Phone Number

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Dependent Children:

Name/Age _____

Name/Age _____

Name/Age _____

Name/Age _____

Emergency Contacts:

1. Name: _____ Relation: _____

Home#: _____ Work #: _____ Cell#: _____

2. Name: _____ 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, therapists, etc) _____

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: _____ | ☐ Endodontic (root canal) Treatment |
| ☐ Periodontal (gum) Treatment | ☐ Complete Dentures |
| ☐ Restorations (fillings) | ☐ Partial Dentures (removable) |
| ☐ Crown & Bridgework (fixed) | ☐ Orthodontic (braces) Treatment |
| ☐ Tooth extraction or oral surgery | ☐ 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 | ☐ Cavities |
| ☐ Crooked Teeth | ☐ Dry Mouth |
| ☐ Bad Bite/Bite feels off | ☐ Frequent sores on mouth/lips |
| ☐ Teeth painful to hot, cold or sweets | ☐ Bleeding gums |
| ☐ Swelling in mouth or jaws on occasion | ☐ Loose or drifting teeth |
| ☐ Food catching between teeth | ☐ Bad taste in mouth |
| ☐ Severe Toothaches | |
| ☐ 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? |

Please explain yes response:

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		
	☐ ☐	Have you ever been told you have heart trouble?	Please explain yes response:
	☐ ☐	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	Y N		
	☐ ☐	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)?	

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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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:
HEMATOLOGY	Y N ☐ ☐ Have you had anemia? ☐ ☐ Do you have leukemia? ☐ ☐ Do you bruise or bleed easily?	Please explain yes response:
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?	Please explain yes response:

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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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:
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?	Please explain yes response:

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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:

_____	_____
_____	_____
_____	_____
_____	_____

We offer dental material compatibility testing for anyone concerned about being allergic to the materials used in our office. Would you like to discuss dental material compatibility testing? Yes ☐ No ☐

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.

Patient Signature: _____ Date: _____

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 #: _____

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).

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

Patient Signature

Date

Printed Name