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 $132. 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 $436. 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/time.

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.

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

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 #: _____

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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):_____

_____

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7. **Attitudes about Dental Health Care**

Y	N		Please explain yes response:
☐	☐	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		Please explain yes response:
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	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:

_____ _____

_____ _____

_____ _____

_____ _____

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:_____

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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 #: _____