



Robert L. Edwards, DDS, PLLC

2830 MAPLEWOOD AVE, SUITE B
WINSTON SALEM N.C. 27103

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____

Phone (Home): _____ (Work): _____ (Mobile) : _____ (Email): _____

May we contact you at any or all of the above numbers and/or email addresses? Yes No

Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |

• Do you use tobacco products and how often? Yes No

If yes, please explain: _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

• Do you currently take any prescription medications? Yes No

If yes, please list name and dosage: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor and staff at the next appointment.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? _____

Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City, State Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

The undersigned acknowledges reading the Informed Consent form and hereby authorizes the Practice to take radiographs, photographs, or study models, and to use any other diagnostic aids deemed appropriate for accurate diagnosis of the patient's dental needs. I also authorize the Practice to perform any and all forms of treatment, medication and therapy that may be indicated. Further, I understand the responsibility of payment for dental services provided to my dependents and myself is due and payable at the time service is rendered unless other financial provisions have been made and agreed upon by both parties. After 90 days, the remaining balance will be charged 1.67% interest or a minimal billing charge of \$3.00 if the percentage of interest totals less than \$3.00.

*****Please Note*****

If you are a patient that receives direct reimbursement from your insurance company, it is your responsibility to pay the balance and/or endorse the insurance check: "Pay to the Order of Robert L. Edwards, DDS, PLLC"

Having received and read the Practice Notice of Privacy, I authorize the use and disclosure of this information for the purposes of treatment, payment, dental care, and referral.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____