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:

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

- 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.

_____ Date: _____
Signature of patient, parent or guardian

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.

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

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

Reset Form | Print form | Save As ...*

*Your option! - Save this file, then email it to 'robertedwardsdds@gmail.com'