Emery L Edwards, D.D.S.
1626 E Pass Rd.
Gulfport, MS 39507-3526
(228) 896-4084

Today's Date_____

Thank you for choosing our office. In order to serve you properly we will need the following information. All information will be strictly confidential. (Please print.)

Patient's Name: (First) (Last) Birth date marital status Home Phone

Address: City State Zip Code

Name of employer: Address Business Phone

Social security number Driver's license Occupation

Do you have dental insurance? ○ **yes** ○ **no** **Insurance Co. name & address** **If no, how do you intend to pay?** ☐ **check** ☐ **cash** ☐ **credit card**

Subscriber name Policy No. Is it through your employer? ○ **Yes** ○ **No**

Name of spouse Date of birth Social security number

Name of spouse employer address

Occupation Business phone

Secondary insurance co. name address Policy no.

Nearest friend or relative that does not live with you Relationship to you Phone

Whom may we thank for referring you?_____

What is your chief complaint?_____

I authorize this office to release any information necessary to expedite insurance claims, if applicable. I understand that I am responsible for all charges, regardless of insurance coverage. If charges are not paid in a satisfactory manner all outsource charges will be my responsibility.

Signature of Patient, Parent, or Guardian_____

Date_____

Mississippi State law requires our office to obtain your consent for any dental treatment. There may be various risks, consequences, and/or complications associated with any dental treatment. This includes the administration of any local anesthetic agent. Please ask us about anything you do not understand and we will be happy to answer your questions. I hereby authorize and direct Dr. Edwards, his hygienist, and his assistants to perform the recommended dental treatment. I also understand that the success of treatment somewhat depends upon my compliance with the oral hygiene instructions given to me and with keeping appointments for follow-up treatment. Authorization is also given to Dr. Edwards to speak with my other healthcare providers or suppliers concerning any matters of my health so he can diagnose and better treat me as a dental patient. This consent form will remain valid until revoked in writing by me.

Signature of Patient, Parent, or Guardian_____

Date_____

Correct answers to the following questions will allow Dr. Edwards to treat you on a more individualized basis, providing the care appropriate for your particular needs. Please answer each of the following questions. If in doubt, leave blank. Your answers will be considered confidential.

DENTAL

Please check if you have had any of the following:

Bleeding gums ☐ **Loose Teeth** ☐ **Bad breath** ☐ **Food packing** ☐ **sore gums** ☐

fever blisters ☐ **Pain in biting** ☐ **Clenching/grinding** ☐ **changes in bite** ☐

Sensitivity to cold, hot, or sweets ☐ **Difficulty opening or closing jaw** ☐

Have you ever had any serious trouble associated with previous dental treatment, and if so, please explain?_____

Have you ever been treated for gum disease, and if so, please provide date(s)?_____

_____

How often do you brush?_____ **Floss**_____ **When did you last have your teeth cleaned?**_____

_____

Name _____ **Birth Date** _____ **Age**_____

MEDICAL

1. Have you had any serious illness or surgery within the last five (5) years, and if so, please explain?

2. My last physical examination was on (date) _____ and the name and address of my physician is _____

3. List all medications currently taking, include over the counter medications.

4. My pharmacy name is:_____

5. List all medications that you have sensitivity or allergic reaction:

Please check any of the following conditions you have or have had in the past.

- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Mitral Valve Prolapse
- ☐ High or low blood pressure
- ☐ Heart pacemaker
- ☐ Hepatitis Type____
- ☐ Kidney disease
- ☐ Artificial joint, pins, or screw
- ☐ Anemia
- ☐ Epilepsy or seizures
- ☐ AIDS or HIV
- ☐ Ulcers
- ☐ Sinus Trouble
- ☐ Arthritis
- ☐ Hemophilia
- ☐ Organ removal or transplant, when_____
- ☐ Prostate or Urinary tract
- ☐ TMJ
- ☐ Heart murmur
- ☐ Artificial heart valve
- ☐ Heart disease or attack
- ☐ Heart Surgery, when_____
- ☐ Liver disease
- ☐ G.I. disorder
- ☐ Cancer or tumor, if so type_____
- ☐ Chemo or radiation therapy, When?_____
- ☐ Emphysema
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid disease
- ☐ Depression or anxiety
- ☐ Venereal disease
- ☐ Glaucoma
- ☐ Tuberculosis

Do you have any disease, condition, or problem not listed which you think I should know? If so, please explain._____

_____

Signature of patient_____ Date_____

SUBMIT