HEALTHY ROOTS
DENTISTRY

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

First Name:_____ M.I.: __ Last Name: _____

Preferred Name: _____ DOB: _____ ☐ Female ☐ Male

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor Social Security #:_____

Address: _____ City:_____ State: _____ Zip:_____

E-mail Address: _____

Preferred Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Referred By: ☐ Website ☐ Facebook ☐ Google ☐ Patient ☐ Doctor Name: _____

Emergency Contact: _____ Phone Number: _____

Who is responsible for this account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name: _____ Social Security #: _____

Preferred Name: _____ DOB: _____

Address: _____ City:_____ State: _____ Zip:_____

Preferred Phone Number: _____ ☐ Cell ☐ Home ☐ Work

DENTAL INSURANCE INFORMATION

To be completed if you have Dental Insurance—**Medicare and Health** insurance do not pay for our services. Please give your Dental Insurance card to the front desk OR text or email a copy to the office.

WE CANNOT FILE YOUR INSURANCE UNLESS YOU PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD

We do not accept assignment of insurance benefits; payment in full is due on the day of the appointment.

Subscriber Name: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Subscriber ID#: _____ Employer: _____

All insurance re-imbursements will be paid directly to you.

Assignment & Release: I authorize the dentist to release any information required for this claim.

Patient or Guarantor's signature: _____