HEALTHY ROOTS
DENTISTRY

PATIENT INFORMATION

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

Preferred Name: _____ DOB: _____ ☐Female ☐Male

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

Guarantor Name: _____ DOB:_____ SS#: _____

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

E-mail Address: _____

Phone Number: _____ ☐ Cell ☐Home ☐Work Alternate Number: _____

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

Emergency Contact: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION (MUST PROVIDE COPY OF DENTAL CARD)

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

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Social Security #: _____ Employer: _____

Assignment & Release: I authorize the dentist to release any information required for dental claims.

Patient or Guarantor's signature:_____

PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. If you need to reschedule or cancel an appointment we require a minimum of a **48 business hours** notice prior to your appointment time. **Please call the office to make a change, 918-982-6644**.

Business hours are Tuesday 8-4 and Wednesday through Friday 8-5. We are closed Saturday, Sunday and Monday.

"No Shows" or last minute cancelations (less than 48 business hours in advance) leave empty appointment times that could be filled by other patients waiting to receive dental care. For that reason, clients that do not honor their appointments will be charged a cancelation fee.

LESS THAN 48 *BUSINESS* HOURS BEFORE YOUR APPOINTMENT TIME AND/OR NO SHOW:

$50 FOR CLEANING APPOINTMENTS
$150 FOR ALL APPOINTMENTS WITH THE DOCTOR OR FOR PERIO PROCEDURES

We realize that on a rare occasion, emergencies may occur and we will address these situations with you at that time. We thank you for working with us to ensure services are provided to you and others in the best way possible!

I fully understand the patient cancelation and no show policy.

Signature: _____ Date: _____

DENTAL HEALTH HISTORY

Name: _____ Today's Date: _____

Major complaint or reason for today's visit: _____

Have you been seen for this condition previously? ☐ Yes ☐No When?: _____

What treatment was done? _____ Treating Dentist: _____

Dental exams on a routine basis? ☐Y ☐N Frequency? _____ Brush Daily? ☐Y ☐N Floss Daily? ☐Y ☐N

When did you last have dental x-rays taken? ☐ Less than 6 months ☐Over 6 months ☐Over a year

Mark any concerns you have about your teeth: ☐ Color ☐ Shape ☐ Spacing ☐ Crowding ☐ Smile
☐ Mercury Fillings ☐ Root Canals ☐ Cavitations ☐ Cavities

Check yes or no if you have had problems with any of the following:

☐Y ☐N	Bad Breath	☐Y ☐N	Grinding or clenching teeth	☐Y ☐N	Sensitivity to hot
☐Y ☐N	Bleeding Gums	☐Y ☐N	Loose teeth	☐Y ☐N	Sensitivity to sweets
☐Y ☐N	Broken filings	☐Y ☐N	Periodontal treatment	☐Y ☐N	Sensitivity when biting
☐Y ☐N	Clicking or popping jaw	☐Y ☐N	Sensitivity to cold	☐Y ☐N	Sores or growths in mouth

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Have your past dental experiences been positive? ☐Y ☐N Explain: _____

What is your level of anxiety/stress/fear of going to the dentist? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Do you have a family history of gum disease? ☐Yes ☐No ☐ Don't know

MEDICAL HEALTH HISTORY

Have you had any illnesses, operations or been hospitalized in the last 5 years? ☐Y ☐N

If yes, explain: _____

Check yes or no whether you have had any of the following:

☐Y ☐N	AIDS/HIV positive	☐Y ☐N	Epilepsy	☐Y ☐N	Psychiatric care
☐Y ☐N	Anaphylaxis	☐Y ☐N	Fainting	☐Y ☐N	Rapid weigh gain/loss
☐Y ☐N	Anemia	☐Y ☐N	Food allergies	☐Y ☐N	Radiation treatment
☐Y ☐N	Arthritis, Rheumatism	☐Y ☐N	Glaucoma	☐Y ☐N	Respiratory disease
☐Y ☐N	Artificial heart valves	☐Y ☐N	Headaches	☐Y ☐N	Rheumatic/scarlet fever
☐Y ☐N	Artificial joints	☐Y ☐N	Heart murmur	☐Y ☐N	Shingles
☐Y ☐N	Asthma	☐Y ☐N	Heart problems	☐Y ☐N	Shortness of breath
☐Y ☐N	Atopic (allergy prone)	☐Y ☐N	Hemophilia/abnormal bleeding	☐Y ☐N	Sleep apnea
☐Y ☐N	Back problems	☐Y ☐N	Herpes	☐Y ☐N	Snoring
☐Y ☐N	Blood disease/bleeding problems	☐Y ☐N	Hepatitis	☐Y ☐N	Stroke
☐Y ☐N	Cancer	☐Y ☐N	High blood pressure	☐Y ☐N	Surgical implant
☐Y ☐N	Chemical dependency	☐Y ☐N	Jaw pain	☐Y ☐N	Swelling of feet/ankles
☐Y ☐N	Chemotherapy	☐Y ☐N	Kidney disease/malfunction	☐Y ☐N	Thyroid disease
☐Y ☐N	Circulatory problems	☐Y ☐N	Liver disease	☐Y ☐N	Tobacco habit
☐Y ☐N	Cortisone treatments	☐Y ☐N	Material allergies (latex, etc.)	☐Y ☐N	Tonsillitis
☐Y ☐N	Cough, persistent	☐Y ☐N	Mitral valve prolapse	☐Y ☐N	Tuberculosis

☐Y ☐N	Cough up blood	☐Y ☐N	Nervous problems	☐Y ☐N	Ulcer/Colitis
☐Y ☐N	Diabetes	☐Y ☐N	Pacemaker/heart surgery	☐Y ☐N	Vertigo

☐Other: _____

Females please fill out the following

Are you currently:

☐Y ☐N Pregnant
☐Y ☐N Nursing
☐Y ☐N Taking birth control pills
☐Y ☐N Taking hormones
☐Y ☐N Peri-menopause
☐Y ☐N Post-menopause

Have you ever been diagnosed with:

☐Y ☐N Breast cancer
☐Y ☐N Cervical or ovarian cancer
☐Y ☐N Endometriosis
☐Y ☐N PCOS
☐Y ☐N Osteoporosis
☐Y ☐N Are you on medication for osteoporosis?

Are you allergic to any medications or substances? Check (✓) all that you are allergic to:

☐Aspirin/advil	☐Codeine	☐Metal
☐Acrylic	☐Latex	☐Penicillin
☐Antibiotics	☐Local anesthetics/novocaine	☐Sulfa

☐Other: _____

Are you a tobacco user? ☐ Yes ☐No

Are you taking any medications? ☐ Yes ☐No

Do you take any blood thinners? ☐ Yes ☐No

Do you take any immunosuppressant medications? ☐ Yes ☐No

Have you had the COVID shot? (This changes what dental anesthetic may be used during treatment) ☐ Yes ☐No

Please list any prescription medications you are currently taking: _____

_____

_____

AUTHORIZATION

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form. IF there is any change in my medial status, I will inform my dentist and his/her staff.

Patient or Guarantor's signature: _____ **Date:** _____

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient or Guarantor's signature: _____ **Date:** _____

Health history form has been completed and reviewed.

Signature of Staff: _____ **Date:** _____