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 FOR CHILD UNDER 12 YEARS

Name: _____ Today's Date: _____

Major complaint or reason for today's visit: ☐ Cleaning ☐ 2nd opinion ☐ Other: _____

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

Problems with any of the following: ☐Y ☐N Grinding or clenching teeth ☐Y ☐N Sensitivity when biting

☐Y ☐N Sensitivity to hot ☐Y ☐N Sensitivity to cold ☐Y ☐N Sensitivity to sweets

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

MEDICAL HEALTH HISTORY

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

If yes, explain: _____

Have you had any of the following:

☐Y ☐N	Anaphylaxis		☐Y ☐N	Epilepsy	☐Y ☐N	Nervous problems
☐Y ☐N	Anemia		☐Y ☐N	Fainting	☐Y ☐N	Psychiatric care
☐Y ☐N	Asthma		☐Y ☐N	Food allergies	☐Y ☐N	Respiratory disease
☐Y ☐N	Cancer		☐Y ☐N	Headaches	☐Y ☐N	Rheumatic/scarlet fever
	☐Y ☐N	Chemo	☐Y ☐N	Heart problems	☐Y ☐N	Shortness of breath
	☐Y ☐N	Radiation	☐Y ☐N	Hepatitis	☐Y ☐N	Sleep apnea
☐Y ☐N	Cough, persistent		☐Y ☐N	Jaw pain	☐Y ☐N	Snoring
☐Y ☐N	Cough up blood		☐Y ☐N	Material allergies (latex, etc.)	☐Y ☐N	Tonsillitis
☐Y ☐N	Diabetes		☐Y ☐N	Had the COVID shot		

☐Other: _____

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 taking any medications? ☐ Yes ☐No Do you take any immunosuppressant medications? ☐ 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:** _____

Doctor Signature: _____ **Date:** _____