



# 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 cancellation 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 cancellation 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:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets
<input type="checkbox"/> Y <input type="checkbox"/> N Broken filings	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> 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:

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