HEALTHY ROOTS
DENTISTRY

918.982.6644
info@healthyrootstulsa.com
www.healthyrootstulsa.com
6128 E 61st St Tulsa, OK 74136

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 dentalhealth.

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

Alternate Phone Number: _____ ☐ Cell ☐Home ☐Work

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

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.

We will NOT be able to file dental insurance for you UNLESS we have a copy of the 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:_____