ROOTED DENTAL CO

Health History Update

First Name: _____ MI_____ Last Name_____

Address: _____ Unit/Apt #_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Have there been any changes to your dental insurance ☐es ☐NO If yes, please update below.

Primary Policy Holder First Name: _____ Last Name: _____

Relation: _____Gender: **M F** S.S # _____ Insurance Co. Name: _____

Policy ID # _____ Group #_____Plan Name: _____

Are you currently under the care of a physician? If yes, please complete the line below. ☐ Yes ☐ No

Date of Last Visit: _____ Physician Name: _____ Physician Phone: _____

Have you been a patient in the hospital during the past five years? Yes NO

Preferred Pharmacy: _____ Pharmacy Location: _____ Pharmacy Phone: _____

Does your physician require you to take antibiotics before a dental visit? Yes ☐ No ☐

Heart Transplant	yes	no	Nose Obstruction	yes	no
Artificial Heart Valve	yes	no	Convulsions/Seizure	yes	no
Lung Disease	yes	no	Neurological Problems	yes	no
Joint Replacement	yes	no	Kidney Disease	yes	no
High Blood Pressure	yes	no	Organ Transplant	yes	no
Heart Condition	yes	no	Osteoporosis	yes	no
Swollen Ankles	yes	no	Tuberculosis	yes	no
Arthritis	yes	no	**Allergy/Sensitivity to**:		
Anemia	yes	no	Penicillin	yes	no
Bleeding/Bruising Tendency	yes	no	Erythromycin	yes	no
Diabetes	yes	no	sulfa	yes	no
Thyroid	yes	no	Codeine	yes	no
Ulcer/Colitis	yes	no	Novocain	yes	no
Herpes	yes	no	Epinephrine	yes	no
HIV Positive	yes	no	Latex	yes	no
Hepatitis/Liver Disease	yes	no	other:		
Cancer	yes	no	_____		
Radiation	yes	no			
Asthma	yes	no			
Bronchitis	yes	no			

Are you currently taking aspirin, Coumadin or other blood-thinning medication? _____ yes no

Please list all medications you take, including aspirin, vitamin and supplements:_____
_____
_____
_____

Cancellation Policy: If for any reason you can not make your appointment, the office requires a 24 hour notice failure to cancel your appointment in this time frame will result in a cancellation/no show fee that will be applied to your account in the amount of $50.00 first offense and $54.00 for each subsequent missed appointment.

I hereby authorize release of any information relating to my insurance claim. I understand that I am responsible for all costs of my dental treatment. I authorize payment to the below named dentist of the group insurance otherwise payable to me.

Patient/Guardian Signature: **Date:**

_____

Provider Signature: **Date:**

_____

Rooted Dental Company PLLC