Welcome to the Office of

My Root Doctor

Your Personalized Root Canal Specialist

Patient Information (*Please print legibly*)

Name:_____ Today's Date_____

Address:_____ Apt#_____

City:_____ State_____ Zip_____ Country_____

Home # (____)_____ Work # (____)_____ Cell # (____)_____

SSN:_____ Date of Birth :_____ Age:_____

Driver License #_____ Married(*M*)/Single(*S*): _____

Email Address:_____

Employer:_____ Occupation:_____

Who Referred You to Us?_____ Your General Dentist:_____

Emergency Contact Information

Name:_____ Relationship:_____ Phone # (____)_____

Medical History

1. **Check** any of the following **which you have had or suspect you have**:

_____Heart Trouble
_____Heart Murmur
_____Mitral Valve Prolapse
_____Rheumatic Fever
_____Artificial Valve
_____Pace Maker
_____High/Low Blood Pressure
_____Artificial Bones/Joints
_____Angina
_____HIV/AIDS
_____Drug/Alcohol Abuse
_____Kidney Trouble
_____Glaucoma
_____Cancer/Chemotherapy/Radiation
_____Severe Headache
_____Bleeding Disorder
_____Thyroid Disease
_____Diabetes
_____Asthma
_____Tuberculosis
_____Ulcers/Colitis
_____Hepatitis A/ B
_____Epilepsy/Seizures/Fainting
_____Psychiatric Problems
_____Liver Disease
_____Other:_____

****Do you require antibiotics prior to any dental treatment?**

_____ YES _____ NO

2. Are you **allergic to** or suffer ill effects from any of the following? (*Please mark all that apply*)

_____Penicillin _____Codeine _____Dental Anesthetics _____Aspirin _____Latex

Other:_____

3. Are you **taking** any of the following? (*Please mark all that apply*)

_____Steroids _____Blood Thinners _____Tranquilizers _____Daily Aspirin

4. Which **medications** are you **currently on**? _____

5. Are you under a physician's care (Chronic) ? _____No _____Yes

6. Women only: Are you pregnant?_____ If yes, week #_____nursing?_____

(TURN OVER)

FINANCIAL AGREEMENT

Our payment policy is **payment as services are rendered.**

You may pay by cash, check, or credit card. We respectfully reserve the right to reschedule an appointment for anyone who cannot meet their co-payment, deposit, or fee for service. I understand that regardless of my insurance status, the fees for services rendered are to be paid within 30 days from the date of service. I agree to this arrangement.

We will gladly accept your dental insurance as a courtesy and will complete the necessary forms with your copayment and deduction. **Accounts past 30 days are subject to 1.5% monthly finance charge, plus any collection fees assessed to the account.**

***Appointments missed or cancelled with less than 48 hours notice may be subject to a $50 No Show fee.**
Appointments cancelled more than 3 times will not be rescheduled*

HIPAA COMMUNICATION CONSENT

_____I hereby authorize that the doctors and staff of My Root Doctor may disclose my personal health information to the person who I have listed as my emergency contact.

_____I hereby authorize that the doctors and staff of My Root Doctor may disclose my personal health information to the following person(s):

Name: _____

Telephone number: _____

Relationship: _____

I understand that at any time I have the right to revoke this consent or request how my protected health information is used or disclosed to carry out treatment, payment, and health care operations.

I understand that any such request of my patient record must be provided by me to the practice in writing.

By my signature below, I affirm the above information.

Signature of Patient: _____ **Date:** _____

Signature of Guardian /Authorized Representative: _____ Date: _____