## PATIENT INFORMATION:

Patient Name:_____________________________________________Nickname:____________________________

Address:________________________________________City:_________________State:_____Zip Code:________

Home#: (____)____________________Cell#: (____)_____________________Work#: (____)____________________

Date of Birth: Gender: SS#:

Email Address:________________________________________________________________________________

Employer:_________________________________________Occupation:_______________________________

## SPOUSE'S INFORMATION:

Spouse's Name:_____________________________________________Nickname:__________________________

Spouse's DOB:________________________________________Spouse's SSN:________________________________

Spouse's Work#: ( ) Spouse's Cell#: (____)__________________________

Employer: Occupation:

Spouse's Name:_____________________________________________Nickname:__________________________

Spouse's DOB:________________________________________Spouse's SSN:________________________________

Spouse's Work#: (____)_________________________________Spouse's Cell#: (____)__________________________

Employer:_________________________________________Occupation:_______________________________

## PARENT/GUARDIAN INFORMATION (if patient is under 18 years of age):

Parent/Guardian Name:___________________________________Nickname:____________________________

Parent/Guardian DOB:____________________________Parent/Guardian SSN:___________________________

Parent/Guardian Work#: (____)_____________________Parent/Guardian Cell#: (____)____________________

Parent/Guardian Employer:_______________________________Occupation:______________________________

## DENTAL INSURANCE INFORMATION:

Insured's Full Name:_________________________________________ SSN and/or Member ID:___________________

Insured's DOB:___________________________________Relationship to Patient:_____________________________

Insurance Company Name:____________________________Insurance Company Phone #: (____)___________

Employer Name:__________________________________________________________________________________

## PATIENT HEALTH HISTORY

In order to render the proper dental care/treatment, please be kind enough to answer the following health history questions. Please "X" each box if the answer is YES, and offer explanations where necessary. Leave blank if the answer is NO. Thank you.

Have you had/do you currently have:

____Heart Problems If yes, please explain:______________________________________________________

____Malignancies If yes, what kind____________________________form of treatment________________

____Radiation Treatments If yes, when/for how long_____________________________________________

____Chemotherapy Treatments If yes, when/for how long__________________________________________

____Hepatitis If yes, what type and when______________________________________________________

____High Blood Pressure ____Rheumatic Fever

____Low Blood Pressure ____Scarlet Fever

____Circulatory Problems ____Tuberculosis

____Diabetes ____Anemia

____Epilepsy ____Herpes

____Kidney Problems ____Nervous Problems

____Asthma ____Cerebral Palsy

____Excessive Bleeding ____Arthritis

____Chronic Sinus ____Chronic Ear Problems

____Knee/Hip/Joint Replacement Surgery If yes, when____________________________________________

____Require pre-medication with antibiotics prior to dental treatment? If yes, what antibiotic do you prefer?_________________________________________________________________________________

Please list any other health complications/medical conditions Dr. Roane should be aware of:_____________________________________________________________________________________

_____________________________________________________________________________________________

Are you pregnant?______ How far along?______________________________

Have you ever tested positive for HIV/AIDS? _________YES_________NO

Please list any and all medications you are currently taking, including OTC pills, vitamins, etc.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Are you allergic to:

_____Penicillin _____Aspirin _____Codeine _____Local Anesthetics ____Sulfa

Any Other Allergies:__________________________________________________________________________

**Dr. Roane and/or his staff often need to contact your other medical doctors and/or dentists for additional treatment information and medical release forms. Please fill out information for any doctors which pertain to you. Thank you.**

Dentist Name:__________________________________Phone#: (____)_________________________

Physician Name:________________________________Phone#: (____)_________________________

OB/GYN Name:__________________________________Phone#: (____)_________________________

Cardiologist Name:_____________________________Phone#: (____)_________________________

Oncologist Name:_______________________________Phone#: (____)_________________________