Patient's Name:_____ **Patient's Birth Date**:_____

(If child)

Father's Name_____ DOB:_____

Mother's Name_____ DOB:_____

Mailing Address:_____City_____Zip_____

Home Phone #_____ Cell Phone #_____ Message #_____

Employer:_____ Work Phone #_____

Social Security No._____

Spouse's Name:_____ DOB:_____

Employer:_____ Work Phone # _____

Social Security No:_____

Referred by:_____

Email_____

Private: _____ Insurance: _____

INSURANCE INFORMATION

Primary Insurance

Name of insured: _____ Social Security No./ID #_____

Insurance Co._____ Group #: _____

Secondary Insurance

Name of insured: _____ Social Security No./ID# _____

Insurance Co. _____ Group # _____

Credit Information

Responsible Party: _____

I agree to pay all fees on the date of service unless specific financial arrangements have been made. I understand that payment is my obligation regardless of insurance or any other third-party involvement. My signature below releases assignment of Insurance Benefits to Riverock Dental. In the even that legal action is brought to collect amount(s) owed to Riverock Dental, the prevailing party shall be entitled to award of a reasonable attorney fee, and venue shall be in Yakima County, Washington.

Signature: _____ **Date:**_____

Patient Name: _____ Date:_____

Chief Dental Complain: _____

Date of Last Dental Visit and X-rays: _____ Name of **Medical** Dr._____

Are you taking any medications at this time? Please list:_____

_____

DO YOU HAVE A MEDICAL CONDITION WHICH REQUIRES PRE-MEDICATION PRIOR TO DENTAL WORK?

_____

Have you had any difficulties with local anesthesia? Please explain:_____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREAT FOR:

	NO	YES	Explain
Heart Murmur----------	☐	☐	_____
Rheumatic Fever----------	☐	☐	_____
Pace Maker----------	☐	☐	_____
Valve Replacement----------	☐	☐	_____
Heart Attack----------	☐	☐	_____
By-Pass Surgery----------	☐	☐	_____
Stroke----------	☐	☐	_____
Abnormal Blood Pressure----------	☐	☐	_____
Ulcers----------	☐	☐	_____
Tuberculosis or lung disease----------	☐	☐	_____
Diabetes----------	☐	☐	_____
Anemia----------	☐	☐	_____
Cancer----------	☐	☐	_____
Venereal Disease----------	☐	☐	_____
Asthma----------	☐	☐	_____
Hepatitis----------	☐	☐	_____
Arthritis----------	☐	☐	_____
Joint Replacement----------	☐	☐	_____
HIV positive (Aids)----------	☐	☐	_____
Cocaine or Street Drug User----------	☐	☐	_____
Seizures----------	☐	☐	_____
ARE YOU ALLERGIC TO:			
Penicillin----------	☐	☐	
Codeine----------	☐	☐	
Local Anesthesia----------	☐	☐	
Sulfa----------	☐	☐	
Latex----------	☐	☐	
Are you subject to prolonged bleeding?	☐	☐	_____
Are you pregnant?----------	☐	☐	**Date Due _____**

Other medical complications? _____

Have you ever been involved with dental/medical legal activity? Yes_____ No____