MARTIN & RODRIGUEZ DENTAL CENTER
PATIENT REGISTRATION

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

Spouse's Name: _____ Spouse's Birth Date:_____

(if Child)

Father's Name: _____ Father's Birth Date:_____

Mother's Name: _____ Mother's Birth Date:_____

Mailing Address: _____City: _____Zip: _____

Home Phone #: _____Cell Phone #: _____Message #: _____

Occupation: _____Employer:_____

Work Phone:_____Social Security No._____

Spouse's Occupation: _____Employer:_____

Work Phone:_____Social Security No._____

Nearest Relative's name: _____Phone #: _____

Referred by: _____

Private: _____ Insurance:_____

INSURANCE INFORMATION

#1 Primary

Name of Insured: _____

Insurance Co.: _____Address:_____

Group #: _____ Local #:_____

#2 Secondary

Name of Insured: _____

Insurance Co.: _____Address:_____

Group #: _____ Local #:_____

CREDIT INFORMATION

Responsible Party: _____

I agree to pay all fees on the date of service unless specific financial arrangements have been made. My signature below releases assignment of Insurance Benefits to Martin & Rodriguez Dental Center. In the event that legal action is brought to collect amount(s) owed to Martin & Rodriguez Dental Center, the prevailing party shall be entitled to the award of a reasonable attorney fee, and venue shall be in Yakima County, Washington.

Signature: _____Date: _____

Patient Name: _____Date: _____
Chief Dental Complaint: _____
Date of Last Dental Visit and X-rays: _____Name of Medical Doctor: _____
Are you taking any medications at this time? Please list: _____

_____

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

HAVE YOU EVER BEEN DIAGONSED WITH OR TREATED FOR:

	No	Yes	Explain
Heart Disease including:			
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 or Hay Fever----------	_____	_____	_____
Hepatitis----------	_____	_____	_____
Arthritis----------	_____	_____	_____
Joint Replacement----------	_____	_____	_____
HIV positive (AIDS)----------	_____	_____	_____
Cocaine or Street Drug User?----------	_____	_____	_____
Seizures----------	_____	_____	_____
ARE YOU ALLERGIC TO:			
Penicillin----------	_____	_____	_____
Codeine----------	_____	_____	_____
Local Anesthesia----------	_____	_____	_____
Sulfa----------	_____	_____	_____
Latex----------	_____	_____	_____
Other Allergies? ----------	_____	_____	_____
Are you subject to prolonged bleeding?	_____	_____	_____

Are you pregnant? No_____ Yes _____ Date Due_____

Other medical complications? _____