Columbia River Endodontics / Dr. Garth Hatch, DDS / Dr. Chad Dawson, DDS
7409 West Grandridge Boulevard Kennewick, WA 99336
At Your Service!

Patient Registration

Date:_____ Reviewed_____

The following information is necessary for proper treatment and will be kept confidential.

Name (Mr., Ms., Miss, Mrs., Dr.)_____ Birthdate _____
Home Address _____ City_____ Zip _____
Home Phone_____ Cell Phone _____SS# _____-_____-_____
Employed By_____ Business Phone _____ Email _____
Name of Referring Dentist _____ Length you have been his/her patient _____ years
Is Dental Treatment Partially Covered by Insurance? Yes □ No □
Name of Insurance Company _____
Party Responsible for Account _____
Emergency Contact _____ Phone _____

FINANCIAL AGREEMENT: I UNDERSTAND THAT THE TOTAL PAYMENT OF DENTAL SERVICES IS MY RESPONSIBILITY. UPON ANY SUIT TO COLLECT PAYMENT REQUIRED BY THIS AGREEMENT, THE PATIENT AGREES TO PAY A REASONABLE SUM OF ATTORNEY'S FEES AND ALL COSTS AND EXPENSES IN CONNECTION WITH SUCH SUIT.

Signed_____

Health History

1. Do you now have or have you ever had any heart trouble? Yes □ No □
2. Have you ever had rheumatic fever or high blood pressure? Yes □ No □
3. Have you ever had any problems with bleeding? Yes □ No □
4. Are you presently under the care of a physician? Yes □ No □

Name of physician(s)_____

5. List any medication taken during the past year _____

_____

6. Have you ever been hospitalized for a serious illness? Yes □ No □

_____

_____

7. Have you ever had kidney disease, liver disease, or diabetes? _____ Yes □ No □

8. Have you ever had problems during dental treatment? _____ Yes □ No □

9. Have you ever had a reaction to any of the following drugs:

	Yes	No		Yes	No			
Penicillin	□	□	Aspirin	□	□	Latex	Yes □	No □
Codeine	□	□	Erythromycin	□	□	Dental Anesthetic	□	□

Other Drugs _____

10. Circle any of the following diseases or conditions that you have had:

Jaundice	Stroke	Hay Fever	Injury to Face or Jaw	Hepatitis	Ulcers
Heart Attack	Blood Transfusion	Tuberculosis	Infectious Disease	Sinus Trouble	Asthma
Epilepsy	Venereal Disease	Fainting			

11. Women: Are you pregnant? Yes □ No □ When is the baby due? _____

12. What is the name of a pain medication that works well for you? _____

I, THE UNDERSIGNED, BEING THE PATIENT, PARENT OR GUARDIAN OF THE ABOVE MINOR PATIENT CONSENT TO THE PERFORMING OF WHATEVER PROCEDURE MAY BE NECESSARY BY THE DOCTOR. I AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH DRUGS AND/OR ANESTHESTICS AS MAY BE DEEMED ADVISABLE BY THE DOCTOR. I ASLO UNDERSTAND THAT UPON COMPLETION OF ROOT CANAL THERAPY IN THIS OFFICE I WILL BE REFERRED TO MY DENTIST FOR A PERMANENT RESTORATION, SUCH AS A COMPOSITE RESTORATION, ONLAY, OR CROWN. I CERTIFY THE ABOVE HEALTH HISTORY TO BE CORRECT. I AUTHORIZE THE RELEASE OF MY TREATMENT RECORD.

Patient's/Parent's Signature:_____ Date: _____