Dr. Jeffrey P Fish DDS * 107 West Main Street * Crosby, MN 56441 * 218/546-6031 * Fax 218/546-8159 * email: info@jpfishdds.com

PATIENT REGISTRATION INFORMATION

Patient Information

First Name: _____

Last Name: _____

Middle Initial: _____ Nickname: _____

Address: _____

Address 2: _____

City: _____ State: ___ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Pager: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Date of Birth: _____ Social Sec. #: _____

Driver's License Number: _____

Email: _____

May we email correspondence? ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Student Status: ☐ Full Time ☐ Part Time

Emergency Contact:_____

Emergency Numbers:_____

Responsible Party Information

(leave blank if same as Patient Information)

First Name: _____

Last Name: _____

Middle Initial: _____ Nickname: _____

Address: _____

Address 2: _____

City: _____ State: ____ Zip Code: _____

_____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Pager: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Date of Birth: _____ Social Sec. #: _____

Driver's License Number: _____

Email: _____

May we email correspondence? ☐ Yes ☐ No

Does your cell phone receive text messages? ☐ Yes ☐ No

☐ Responsible Party is also a Policy Holder for Patient

☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

Insurance card must be presented at time of appointment.

Responsible Party Employment Information

Employer: _____

Employer Address: _____

Employer Address 2: _____

Employer City: _____

Employer State: _____ Employer Zip Code: _____

Employer Phone Number: _____

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MEDICAL/DENTAL HISTORY

Current Physician _____ Location _____ Office Phone _____ Date of Last Exam: _____

❑ Yes ❑ No Are you under a physician's care now?
If yes, please explain: _____
❑ Yes ❑ No Have you ever been hospitalized/major operation?
If yes, please explain: _____
❑ Yes ❑ No Have you ever had a serious head or neck injury?
If yes, please explain: _____
❑ Yes ❑ No Are you taking any medications, pills, or drug?
If yes, please explain: _____
_____
_____
❑ Yes ❑ No Do you take, or taken bone building drugs?
❑ Yes ❑ No Do you take, or taken, Phen-Fen or Redux?
❑ Yes ❑ No Do you use controlled substances?
❑ Yes ❑ No Do you use tobacco?
❑ Yes ❑ No Are you on a special diet?

Are you allergic to or have you had any reactions to the following:
❑ Yes ❑ No Aspirin
❑ Yes ❑ No Penicillin or any other Antibiotics
❑ Yes ❑ No Codine
❑ Yes ❑ No Acrylic
❑ Yes ❑ No Any Metals (eg. nickel, mercury, etc)
❑ Yes ❑ No Latex Rubber
❑ Yes ❑ No Local Anesthetics (eg. novocaine)
❑ Yes ❑ No Sulfa Drugs
❑ Yes ❑ No Other _____

Women Only: (check all that apply)
❑ Yes ❑ No Are you taking oral contraceptives?
❑ Yes ❑ No Are you pregnant/trying to get pregnant?
❑ Yes ❑ No Are you nursing?

Do you have, or have you had, any of the following medical conditions? (check all that apply)

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis/Gout
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells/Dizziness
❑ Frequent Cough
❑ Frequent Headaches
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart - Murmur
❑ Heart - Pace Maker
❑ Heart - Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spina Bifida
❑ Stomach/Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers

Have you ever had any serious illness not listed above? ❑ Yes ❑No If yes, please explain:_____

Previous Dentist _____ Location _____ Office Phone _____ Date of Last Exam: _____

Do you have, or have you had, any of the following dental conditions? (check all that apply)

❑ Bleeding gums while brushing or flossing
❑ Sensitivity to hot/cold liquids/foods
❑ Sensitivity to sweet/sour liquids/foods
❑ Pain to any of your teeth
❑ Sores or lumps near your mouth
❑ Head, neck or jaw injuries
❑ Frequent Headaches

Experienced any of the following in your jaw:
❑ Clicking
❑ Pain
❑ Difficulty in opening or closing
❑ Difficulty in chewing
❑ Clenching or grinding of teeth
❑ Frequent biting of lips or cheeks
❑ Orthodontic treatments

❑ Difficult extractions in the past
❑ Prolonged bleeding following extractions
❑ Wear dentures or partials, if yes date of replacement: _____
❑ Received oral hygiene instructions regarding the care of your teeth and gums
❑ Like your smile

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's Name _____

Signature (parent if patient is under the age of 18) _____ **Date** _____

Print Name (parent if patient is under the age of 18) _____ **Staff Initials** _____