CROSBY
FAMILY DENTISTRY

Thank you for choosing Crosby Family Dentistry. Your dental health is an important factor in maintaining your overall health. Our staff is committed to providing you with high quality dental care in a caring and professional manner. We are sending this letter to help you prepare for your first office visit.

**Please arrive 15 minutes prior to your scheduled appointment time with the completed enclosed documents.**

*Use the following checklist as a reminder of the things to take care of for your first visit:*

- ✓ **Consent for Use and Disclosure of Health Information** - form is enclosed, please review and sign and bring to your first visit
- ✓ **Request for dental records and X-ray's** - fill this out today and send to your most recent dental provider, so we will have your records for your first visit
- ✓ **Acknowledgment of Receipt of Notice of Privacy Practices** - form is enclosed, please review and sign after reviewing the Notice of Privacy Practices and bring to your first visit
- ✓ **Financial Policy** - form is enclosed, please review and sign and bring to your first visit
- ✓ **Insurance Card** - if you have insurance, bring your insurance provider card to your first visit
- ✓ **Photo ID**

On your first visit you can expect: A thorough examination and assessment of your oral health, including necessary x-rays; a careful evaluation of your dental status; and, a recommended treatment plan to meet your oral health goals.

If you have any conditions that require antibiotic prophylaxis please call your primary care physician for a prescription to take prior to your appointment. It is important for you to take medication prior to your appointment to prevent complications.

Your time is valuable, and except for emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. It is our policy to charge $100 for failed appointments, and to discharge patients after three failed appointments without 24-hour notice.

Our office is open Monday through Thursday from 8am - 4pm. If you have any questions, feel free to call.

We look forward to helping you maintain your oral health.

Heather Cline
Office Manager

107 West Main Street — Crosby, MN 56441
Phone: 218-546-6031 — Fax: 218-546-8159 — Email: info@crosbyfamilydentistry.com

Crosby Family Dentistry * 107 West Main Street * Crosby, MN 56441 * 218/546-6031 * Fax 218/546-8159

email: info@crosbyfamilydentistry

# 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 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 Codeine
❑ Yes ❑ No Acrylic
❑ Yes ❑ No Any Metals (eg. nickel, mercury, etc)
❑ Yes ❑ No Latex Rubber
❑ Yes ❑ No Local Anesthetics (eg. Novocain)
❑ 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

Experience any of the following in your jaw:
❑ Clicking
❑ Pain
❑ Difficulty in opening or closing
❑ Difficulty in chewing
❑ Clenching or grinding 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**

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# ORAL HEALTH RISK FACTORS

Your honest responses to these questions will help assess your risk for serious oral diseases, including cancer. All responses are confidential and will only be used in determining a diagnosis and/or oral health plan.

**Patient's Name:** _____

☐ Yes ☐ No **1. Have you EVER smoked cigarettes?** (if no, proceed to question 2)

**The amount that you are presently smoking** (check all that apply)

☐ None (quit smoking completely) ☐ <1 pack of cigarettes/day ☐ An occasional cigar
☐ An occasional cigarette ☐ 1-2 packs of cigarettes/day ☐ Cigars on a daily/regular basis
☐ A few cigarettes per day ☐ 2 or more packs of cigarettes/day ☐ Occasional pipe smoker
☐ A pipe on a daily/regular basis

**If you quit smoking, when did you quit?**

☐ <6 months ago ☐ 6 months to a year ago ☐ 1 to 3 years ago ☐ > 3 years ago

**How many years have you smoke?**

☐ < 2 years ☐ 2-5 years ☐ 5-10 years ☐ 10-20 years ☐ > 20 years

☐ Yes ☐ No **2. Have you ever chewed tobacco, used snuff or other similar substance?** (If no, proceed to question 3)

☐ Yes ☐ No **Are you still using smokeless tobacco or snuff?**

**If no, when did you quit?**

☐ <6 months ago ☐ 6 months to a year ago ☐ 1 to 3 years ago ☐ > 3 years ago

**How many years have you use chewing tobacco/snuff/etc?**

☐ < 1 year ☐ 1-2 years ☐ 2-5 years ☐ > 5 years

☐ Yes ☐ No **3. Do you consume alcoholic beverages?** (if no, proceed to question 4)

**Approximate average amount of alcoholic beverages presently consumed/week:**

☐ None ☐ < 1/week ☐ 1-5 drinks ☐ 6-11 drinks ☐ 11-20 drinks ☐ > 20 drinks

☐ Yes ☐ No **4. Do you have or have you ever had a substance abuse problem?**
(If yes, please describe): _____

☐ Yes ☐ No **5. Do you presently use recreational drugs?**
(If yes, please list): _____

☐ Yes ☐ No **6. Do you have or have you ever had an eating disorder?**
(If yes, please describe): _____

☐ Yes ☐ No **7. Do you have or have you ever had any head, neck or mouth piercing(s)?** (Other than ears)
(If yes, please describe): _____

☐ Yes ☐ No **8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)?**

**9. Please list your history or any family member's history of cancer:**

_____

_____

**10. Other concerns and considerations:**

_____

_____

CONSENT – To the best of my knowledge, all the preceding information is correct and if there is ever any change in health, or medications, this prac will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's healt information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by thi practice for the above-named individual until further notice. I understand there are no guarantees or warranties in health or dental care

_____ ___/___/____ _____ ___/___/____

**Patient or guardian signature** **Date** **Jeff P Fish DDS staff signature** **Date**