Phone: 320.393.2215
Address: 20 16th Ave. S.W.
P.O. Box 190
Rice, MN 56367

Patient Information

Date:______________ ID#/SS#______________

Patient:______________

Address:______________

____

Sex: M F Age:________ Birthdate:______________

Occupation:______________

Employer:______________

Employer Address:______________

Employer Phone:______________

Spouse's Name:______________

Birthdate:________ SS#______________

Occupation:______________

Spouse's Employer:______________

Whom may we thank for referring you?:______________

Contact Information

Home:______________

Work:______________ Ext.________

Cell:______________

Best time and place to reach you:______________

Emergency Contact

Name:______________

Relationship:______________

Home:______________

Work:______________

Cell:______________

Dental Insurance

Who is responsible for this account?______________

Relationship to Patient:______________

Insurance Co.:______________

Group #______________

Is patient covered by additional insurance? Yes No

Subscriber's Name:______________

Birthdate:______________

Relationship to Patient:______________

Insurance Co.:______________

Group #______________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with______________ and assign directly to Drs. Hyytinen and/or Trobec all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that payment is due when service is rendered and that the doctor will only accept those insurance benefits that I submitted on or before the day services were provided. I further understand that any insurance benefits submitted after treatment has been delivered will not be accepted by the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

Dental History

Reason for today's visit:______________

____

Former Dentist:______________

City/State:______________

Date of last dental visit:______________

Date of last dental X-rays:______________

Please cirle if you have had any of the following:

Bad Breath	Yes	No
Bleading gums	Yes	No
Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collection between the teeth	Yes	No
Foreign objects	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw pain or tenderness	Yes	No
Lip or cheek biting	Yes	No
Loose teeth or broken fillings	Yes	No
Mouth Breathing	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Peridontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No
Sores or growths in your mouth	Yes	No
Do you snore	Yes	No

How often do you floss?______________

How often do you brush?______________

Health History

Physician's Name: ______________________ Date of last visit: ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations Ionimin, Apdipex, Fastin (brand names of phentemine), Prondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Please indicate if you have had any of the following: *Please circle all that apply*

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Athritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Astma	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis Type________	Yes	No	Special Diet	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Swollen Feet or Ankles	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Thryoid Problems	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesions	Yes	No	Low Blood Pressure	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Cough, persistent or bloody	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No	Weight Loss, unexplained	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No			
			Radiation Treatment	Yes	No			

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date: ______________________ Are you nursing: Yes No
Are you taking birth control pills? Yes No

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment, obtaining payment from my dental benefits provider, and the day-to-day healthcare operations of your practice. I have also been informed that a copy of the HIPAA and or copy of your Notice of Privacy Practices is available for my review upon request.

Medications

List any medications you are taking and the correlating diagnosis:

____

____

Pharmacy Name: ______________________

Phone: ______________________

Allergies *Please circle all that apply*

Aspirin	Barbituates (Sleeping Pills)
Codeine	Iodine
Latex	Local Anesthetic
Penicillin	Sulfa

Other ______________________

____

Authorization

I affirm that I have reviewed all of the information disclosed on this document and that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist and his staff to perform the necessary dental services I may need.

My method of payment will be: ______________________

______________________ ______________________

Responsible Party Signature Relationship Date