



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 circle if you have had any of the following:

Bad Breath	Yes	No
Bleeding gums	Yes	No
Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No

Chew on one side of mouth	Yes	No	Mouth pain, brushing	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Orthodontic treatment	Yes	No
Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Dry mouth	Yes	No	Periodontal treatment	Yes	No
Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Foreign objects	Yes	No	Sensitivity to sweets	Yes	No
Grinding teeth	Yes	No	Sensitivity when biting	Yes	No
Gums swollen or tender	Yes	No	Sores or growths in your mouth	Yes	No
Jaw pain or tenderness	Yes	No	Do you snore?	Yes	No
Lip or cheek biting	Yes	No	How often do you floss? _____		
Loose teeth or broken fillings	Yes	No	How often do you brush? _____		
Mouth Breathing	Yes	No			

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, Adipex, Fastin (brand names of phentermine), Pondimin (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	Emphysema	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Psychiatric Problems	Yes	No
Arthritis	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Glaucoma	Yes	No	Sinus Problems	Yes	No
Date: _____			Frequent Headaches	Yes	No	Stroke	Yes	No
Type: _____			Heart Murmur	Yes	No	Thyroid Problems	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Tuberculosis	Yes	No
Back Problems	Yes	No	Hepatitis Type _____	Yes	No	Tumor or growth on		
Bleeding abnormally, with			Herpes / Fever Blister	Yes	No	head or neck	Yes	No
extractions or surgery	Yes	No	High Blood Pressure	Yes	No	Stomach Ulcer	Yes	No
Blood Transfusion	Yes	No	Jaw Pain	Yes	No	Venereal Disease	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No	Weight Loss, unexplained	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No			
			Low Blood Pressure	Yes	No			
			Mitral Valve Prolapse	Yes	No			
			Nervous Disorder	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), obtain payment from my dental benefits provider, and for 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 Penicillin
Codeine Local Anesthetic
Latex

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