Hyytinen-Trobec Family Dental

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 of services were provided. I further understand that any insurance benefits submitted after treatment has been delivered will not be acepted by the doctor. I understand that I am financialy 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 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 tounge	Yes	No
Chew on one side 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
Periodontal 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?_____

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____