PATIENT INFORMATION

Date_______________

Name_______________________________________ Birth Date__________________

Address____
Street City Zip

Home #______________ Cell #________________ E-Mail Add________________

Single ___ Married __ Widowed __ Divorced __ Spouse's Name___________

Soc. Sec. # _____________________ Preferred Name ________________
Height __________ Weight__________

HOW OR BY WHO WERE YOU REFERRED TO OUR OFFICE? ________________

RESPONSIBLE PARTY

Name___________________________________ Soc. Sec. # ____________________

Address____
Street City Zip
Previous Address (if less than 5 years)

____
Street City Zip
Home Phone ________________________ Relationship to Patient ___________
Employer ___________________________ Occupation ____________________
Address ____
Street City Zip
Birth Date __________________ Work Phone # _________________
Spouse's Name ____________________________ Spouse's D.O.B ________________
Spouse's Employer ____________________ Occupation ____________________
Address ____
Street City Zip
How long on the job? ___________________ Work Phone # _________________

INSURANCE INFORMATION

A. PRIMARY CARRIER
Name of insured ________________________ Soc. Sec. # of insured ____________
Dental insurance name ___________________ Phone # _______________________
Group # ______________ Union or Local # ___________________________
B. SECONDARY CARRIER (If Applicable)
Name of insured ________________________ Soc. Sec. # of insured ____________
Dental insurance name ___________________ Phone # _______________________
Group # ________________ Union or Local # ___________________________

MEDICAL HISTORY

General health (Check) ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Name & Address of Physician ____
Date of Last Complete Physical ___________________________
Have you been under the care of a physician during the past two years? ( ) Yes ( ) No
Have you been hospitalized during the past two years? ( ) Yes ( ) No
Have you been or are you an IV drug user? ( ) Yes ( ) No

Circle any of the following, which you have had or have at present:

Mitro Valve Prolapse	Yellow Jaundice	Thyroid Disease
Heart Disease or Attack	Cold Sores	X-ray or Cobalt Treatment
Angina Pectoris	Epilepsy or Seizures	Chemotherapy
High Blood Pressure	Persistent Diarrhea & Fever	Arthritis
Rheumatic Fever	Weight or Appetite Loss	Rheumatism
Heart Murmur	Night Sweats	Cortisone Medicine
Congenital Heart Lesions	Glaucoma	AIDS
Artificial Heart Valve	Emphysema	Blood Transfusion
Heart Pacemaker	Cough	HIV Positive
Heart Surgery	Tuberculosis (TB)	Hemophilia
Anemia	Lung Disease	Fainting or Dizzy Spells
Stroke	Blood Clots	Nervousness
Kidney Trouble	Pulmonary Embolism	Psychiatric Treatment
Ulcers	Asthma	Sickle Cell Disease
Hepatitis (Infectious)	Sinus Trouble/Hay Fever	Skin Rashes or Lesions
Hepatitis (Serum)	Allergies or Hives	Swollen Lymph Nodes
Hepatitis (A),(B),(C)	Liver Disease	Fatigue
Prosthetic Joints	Diabetes	Drug Addiction

What, if any, medications are you presently taking? ______________________________
____
____

Are you allergic to:	Nickel	Yes ( )	No ( )
	Rubber	Yes ( )	No ( )
	Penicillin	Yes ( )	No ( )
	Codeine	Yes ( )	No ( )
	Sulfa	Yes ( )	No ( )
	Local injected Anesthetics	Yes ( )	No ( )
	Other Medications ______________________________________		

Are you a bleeder? Yes ( )No ( )

Women:	Are you taking Oral Contraceptives	Yes ( )	No ( )
	Are you Pregnant?	Yes ( )	No ( )
	Are you nursing?	Yes ( )	No ( )

DENTAL HISTORY

Reason for Visit ____

Are you having pain or discomfort at this time?	Yes ( )	No ( )
Have you ever been treated by an Orthodontist?	Yes ( )	No ( )
Have you ever been treated by a Periodontist?	Yes ( )	No ( )
Do you have swelling or bleeding gums?	Yes ( )	No ( )
Have you ever had a bad experience at a dentist?	Yes ( )	No ( )
Are you happy with your smile?	Yes ( )	No ( )
Do you clench or grind your teeth?	Yes ( )	No ( )
Does your jaw lock or catch?	Yes ( )	No ( )
Are your jaw muscles tense or tired?	Yes ( )	No ( )
Do you have a tic or nervous facial twitch?	Yes ( )	No ( )
Do you have difficulty opening wide?	Yes ( )	No ( )
Are your teeth sensitive to temperature changes?	Yes ( )	No ( )
Do you have frequent headaches or neckaches?	Yes ( )	No ( )

What area of the head? ____

How long do they last? ____

Please describe any emotional problems you have regarding your teeth: _______________
____

Check any of the following daily activities that cause pain or discomfort? Indicate pain type you experience.

Yawning ( )	Brushing teeth ( )	Sharp ( )	Throbbing ( )
Chewing ( )	Turning neck ( )	Dull ( )	Diffused ( )
Swallowing ( )	Turning head ( )	Aching ( )	Constant ( )
Speaking ( )	Turning trunk ( )	Deep ( )	Intermittent ( )
Singing ( )	Moving arms ( )	Superficial ( )	Cyclic ( )
Shouting ( )	Moving shoulders ( )		

What is the intensity of your pain? Mild ( ) Moderate ( ) Severe ( )

What is the longest period you have gone without pain? _____________________

What medication, if any, do you take to relieve your pain? ____________________

Do you ever notice any of the following problems with either of your ears?

Ringing	( ) R L	Itchy feeling	( ) R L
Popping noises	( ) R L	Hearing loss	( ) R L
Stuffiness	( ) R L	Hearing sensitivity	( ) R L
Pain	( ) R L	Grating	( ) R L

EMERGENCY INFORMATION

Name of Nearest Relative____
(Not living with you)

Relationship________________________________

Address____
Street City Zip

Phone___________________________

I believe this to be true to the best of my knowledge.

I understand that a credit bureau report may be obtained.

I understand that I am financially responsible for any Incurred charges not covered by my dental insurance, And that my out of pocket is due the day of treatment.

I agree to pay Belleville Dental Center Ltd., any costs and expenses Of collection agencies, court costs, and/or attorneys necessary for Collection of my account.

I give Dr. Engelage permission to use photos in dental journals and/or marketing medias.

Date____________________________ Signed_____________________________
(Parent, if patient is a minor)