

## 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            |
| Cancer                   |                             |                           |

What, if any, medications are you presently taking? \_\_\_\_\_

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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?

- |                |         |                     |         |
|----------------|---------|---------------------|---------|
| Ringling       | ( ) 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 understand that after all insurance payments are received the amount left over is  
my responsibility and will be due upon receipt. If any balance is carried through  
Belleville Dental Center Ltd there will be a 2% finance charge each month until  
balance is paid in full.**

**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.**

**Since appointed times are reserved exclusively for each patient we ask that you please  
notify our office 24 hours in advance of your scheduled appointment time if you are unable  
to keep your appointment or a \$35 missed/late cancel fee will apply. Another patient who  
needs our care could be scheduled if we have sufficient time to notify them. We realize  
that unexpected things can happen, but we ask for your assistance in this regard.**

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

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Parent, if patient is a minor)