

PATIENT INFORMATION

Date _____

Name _____ Birth Date _____

Preferred Name _____

Address _____
Street City Zip

Home # _____ Cell # _____ E-Mail Add _____

Employer _____ Employer Phone # _____
Employer Address _____

Single ___ Married ___ Widowed ___ Divorced ___ Spouse's Name _____

Soc. Sec. # _____

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

RESPONSIBLE PARTY

Name _____ Soc. Sec. # _____

Relationship to Patient _____ Birth Date _____

Address _____
Street City Zip

Previous Address (if less than 5 years)

_____ Street City Zip

Home Phone _____ Relationship to Patient _____ Birth Date _____

Employer _____ Occupation _____ Work Phone # _____

Address _____
Street City Zip**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? _____

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 ()

Height _____ Weight _____

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
Stiffness	() 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 give Dr. Engelage permission to use photos in dental journals and/or marketing medias.
Yes _____ No _____

Facts You Should Know About Dental Insurance

Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, we would like to share some facts about dental insurance with you.

- We file **dental insurance** claims as a **courtesy** to our patients.
- You may receive a letter from your insurance company stating dental fees are higher than usual and customary. An insurance company surveys a geographical area, finds the average fee, and then takes 90% of that fee and considers it customary. Included in the fee survey are discount clinics, which bring the average down. Any doctor in private practice will have fees considered higher than average.
- Dental Insurance is not meant to be a PAY-ALL; it is only meant to be an aid.
- Many plans tell their insured they'll be covered "up to 80% or up to 100%" but do not clearly specify plan fee schedule allowance, annual maximum or limitations.
- It has been the experience of many dentists that most insurance companies tell their insured "fees are above the usual and customary fees" rather than saying "our benefits are low".
- Many routine dental services are NOT covered by insurance carriers.

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. I understand that a credit bureau report may be obtained. Please be aware we cannot guarantee this estimate and there may be a balance after insurance pays. Whenever choosing this option, we ask you leave a credit card on file for any balance that may be owed after the claim has been processed.

Name on Card

Card #

Exp. Date

CVV

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 believe this to be true to the best of my knowledge

Signed _____ Date _____

(Parent, if patient is a minor)

