WELCOME TO OUR OFFICE!

Please fill in the appropriate information

Date:_____

Name: _____ **Nickname:** _____
Address: _____ **Home Phone:** _____
City, State, Zip: _____ **Birthdate:** _____
Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Age: _____ Sex:_____

E-mail address for appointment reminders:_____

Employer:_____ Occupation: _____ Phone: _____
Spouse's Name:_____ Employer:_____ Phone: _____

Children (give names and dates of birth): _____

Person responsible for account: _____

Is TMJ treatment covered by your dental or medical insurance? ☐ YES ☐ NO (Please bring your insurance card for us to photocopy)
Insurance Company: _____
Subscriber: _____ Social Security # _____
ID number:_____ Birth date of subscriber:_____
Insurance **Phone number:** _____ Do you use a **Reimbursement Account** (flex plan, cafeteria plan)? ☐ Yes ☐ No

Patient's General Dentist: _____ Phone: _____
Patient's Physician: _____ Phone: _____
Whom may we thank for referring you?_____ Relatives treated here: _____
Has there been previous orthodontic or TMJ treatment or evaluation? ☐ Yes ☐ No
Chief reason treatment is being sought? _____

GENERAL SYMPTOMS

1. When did you first notice this condition? _____
   Describe changes since then _____
2. Your problem is in your: ☐ ear ☐ jaw-joint ☐ teeth ☐ face ☐ neck ☐ eye ☐ back of head
   Other _____
3. Is it located in the ☐ right ☐ left ☐ both sides
4. Do you feel any difference between the two sides? ☐ yes ☐ no
   Describe _____
5. Would you call your problem : ☐ simple concern ☐ suffering ☐ other
   Describe _____
6. Does it hurt or is it just uncomfortable? Describe _____
7. ☐ yes ☐ no Does the pain or discomfort disturb your sleep?
8. ☐ yes ☐ no Does the pain or discomfort interfere with daily activities? How? _____
9. ☐ yes ☐ no Is there constant or recurring pain: ☐ right ☐ left Where? _____
10. ☐ yes ☐ no Burning pain: ☐ right ☐ left Where? _____
11. ☐ yes ☐ no Dull, aching pain: ☐ right ☐ left Where? _____
12. ☐ yes ☐ no Stabbing severe pain: ☐ right ☐ left Where? _____
13. ☐ yes ☐ no Can you locate a specific site of pain? ☐ right ☐ left Where? _____
14. ☐ yes ☐ no Does it hurt when you chew? Where? _____
15. ☐ yes ☐ no Does it hurt to open wide or to take a big bite?
16. ☐ yes ☐ no Does your jaw make "clicking or popping" sounds when you chew? ☐ right ☐ left
17. ☐ yes ☐ no Does your jaw "feel tired" after a big meal? ☐ right ☐ left
18. ☐ yes ☐ no Do you have ear pain? Where? _____
19. ☐ yes ☐ no Do you have pain in front of the ears? When? _____
20. ☐ yes ☐ no Do you have pain in the face, jaws eyes, throat, neck or temple region?
    Describe _____
21. ☐ yes ☐ no Do you suffer from chronic headaches? When? _____
    Where: _____
22. ☐ yes ☐ no Is the condition worse ☐ in the morning ☐ during the day ☐ evening ☐ while sleeping ☐ after eating ☐ after speaking?
23. ☐ yes ☐ no Do you prefer one side in chewing? Which side? ☐ right ☐ left
24. ☐ yes ☐ no Do you chew exclusively on one side? Which side? ☐ right ☐ left
25. ☐ yes ☐ no Has anyone heard you grind your teeth in your sleep? ☐ yes ☐ no During the day? ☐ yes ☐ no
    How often? _____
26. ☐ yes ☐ no Are you aware that you clench your teeth during the day? When? _____
    How often? _____
27. ☐ yes ☐ no Have you ever had chronic neck, shoulder, or back pain? When?_____ How often? _____
28. ☐ yes ☐ no Do you notice any of the following:

☐ Hearing loss	☐ right ☐ left	☐ Stuffiness in the ears	☐ yes ☐ no
☐ Pain in the teeth on arising	☐ right ☐ left	☐ Ringing in the ears	☐ yes ☐ no
☐ Headaches	☐ right ☐ left	☐ Throbbing in the ears	☐ yes ☐ no
☐ Neck Pain	☐ right ☐ left	☐ Dizziness	☐ yes ☐ no
☐ Popping, clicking or grating sounds in the jaw?	☐ right ☐ left	☐ Difficulty in swallowing	☐ yes ☐ no

MEDICAL HISTORY

Do you have a history of any of the following:

☐ Heart Trouble	☐ Anemia	☐ Kidney Problems	☐ Hepatitis
☐ HIV positive or AIDS	☐ Allergies	☐ Asthma	☐ Hay Fever
☐ Rheumatic Fever	☐ Diabetes	☐ Epilepsy	☐ Prolonged bleeding
☐ Fainting or dizziness	☐ Tonsils/adenoids removed	☐ Frequent canker sores or fever blisters	
☐ Wear contact lenses	☐ Laytex Allergy	**☐ NONE APPLY**	

☐ **Other serious illnesses (specify)** _____

1. List any drugs or medications now being taken: _____

2. ☐ yes ☐ no Do you have a history of emotional problems?
3. ☐ yes ☐ no Have you had a psychological evaluation or treatment? Describe: _____
4. ☐ yes ☐ no Are you under stress? ☐ mild ☐ moderate ☐ severe
5. ☐ yes ☐ no Have you ever had general anesthesia? When: _____
6. ☐ yes ☐ no Was there ever an accident or blow to the jaw or teeth? When: _____
   Describe: _____
7. ☐ yes ☐ no Have you ever had a whiplash? When: _____
   Any Treatment? _____
8. ☐ yes ☐ no Was there a strain or stretching of the jaw such as yawning, during a dental procedure, while chewing or opening the mouth wide?
   Describe: _____
9. ☐ yes ☐ no Have you ever had Ulcers or a similar disorder? If so describe: _____
10. ☐ yes ☐ no Do you have: ☐ pain in the abdomen ☐ hot flashes ☐ night sweats ☐ trouble breathing
11. ☐ yes ☐ no Are you frequently nauseated? If so when: _____
12. ☐ yes ☐ no Relative to these conditions, have you consulted another specialist? If so, what was the nature? _____
13. ☐ yes ☐ no Are you under medical treatment now? If so, what for: _____
14. ☐ yes ☐ no Are you taking any medication now for pain? If so, what: _____ Dosage _____
    How often? _____
15. ☐ yes ☐ no Have you recently had a ☐ cold ☐ throat infection ☐ tooth infection
16. ☐ yes ☐ no Do you have high blood pressure? Your most recent blood pressure was _____

FEMALES ONLY

17. ☐ yes ☐ no Are you pregnant? ☐ yes ☐ no Are you taking ☐ birth control pills ☐ hormone or glandular medications
    If so, what type? _____
18. ☐ yes ☐ no Do you have headaches with ☐ menstruation ☐ menopause

DENTAL HISTORY

1. ☐ yes ☐ no Have you ever sucked your thumb or fingers?
2. ☐ yes ☐ no Do you breathe through the mouth more than through the nose?
3. ☐ yes ☐ no Have you been informed of any ☐ missing ☐ extra permanent teeth?
4. ☐ yes ☐ no Are you especially apprehensive towards dental visits?
5. ☐ yes ☐ no Are any of your teeth ☐ worn badly ☐ loose ☐ sore
6. ☐ yes ☐ no Have you had any permanent teeth extracted? When: _____
7. ☐ yes ☐ no Have you had recent ☐ fillings ☐ crowns When: _____
8. ☐ yes ☐ no Have you worn braces or had your teeth straightened? If so when: _____
   By whom: _____
9. ☐ yes ☐ no When were your last dental x-rays? _____
   By whom: _____

CONCLUDING QUESTIONS

1. What does this problem keep you from doing? _____

2. Other comments you wish to add:

   _____

3. Describe your diet:
   Breakfast _____
   Lunch _____
   Dinner _____
   Snacks _____
   Vitamins, minerals, other supplements (please list) _____

►I consent to the taking of diagnostic radiographs, photographs, and study models before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.

► I authorize release of any information including diagnosis and record of any treatment of the above named patient to third party payors and/or health practitioners.

►I authorize and request my insurance company (if applicable) to pay directly to the office any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment of all services rendered on my behalf.

_____ _____

RESPONSIBLE PARTY DATE