I. PATIENT DATA

IF YOU ARE BEING SEEN AS THE RESULT OF AN ACCIDENT, PLEASE LIST THE DATE OF THE ACCIDENT: ______________________________

PERSONAL INFORMATION:

Last Name____First Name___________________________________ MI__________

Wishes to be called____

Phone: HOME(   )_______________Work(   )______________Pager (   )________________Cell (   )__________________

Where do you prefer to receive calls? _______Home _______Work _______Auto   Other______________________________

What is the best time to reach you?   Time__________________   Days____

Address____

City, State, Zip____

Birthdate__________________________ Soc. Sec. #____________________________________ DL#___________________________

Male_____________   Female______________

Employer____Occupation______________________________

________Minor   ________Single   ________Married   ________Divorced   ________Widowed   _______Separated

In the event of an emergency, whom should we contact?

Name_________________________Relationship_____________ Phone(   )______________________

RESPONSIBLE PARTY: **___Same as above**

Last Name____________________________________First Name__________________________MI_________

Relationship to patient____

Phone: Home(   )_______________Work(   )______________Pager (   )________________Cell (   )__________________

Address____

City, State, Zip____

Birthdate________________________ Soc. Sec. #____________________________________ DL#______________________________

Employer____Occupation____________________________________

Are you here as a result of an automobile accident?   __________YES   __________NO

INSURANCE INFORMATION:

AUTO (PIP) INSURANCE:

IF YOU HAVE A TORT AUTO INSURANCE PLAN (RENEWED AFTER 7/1/02), DO YOU HAVE MEDPAY AND/OR UNINSURED MOTORIST OPTION? _____YES ____NO IF YOU HAVE MEDPAY, DO YOU HAVE A PPO OPTION? ____YES ____NO

Has accident been reported?____YES ____NO WHO RECEIVED THE TICKET?______________________________

Insured's Name____________________ ___________________________ Insured's Relationship____________________________________

Insured's Date of Birth________________________________Insured's Soc. Sec. #____

Is this a PPO? ____YES ____NO If yes, name of Managed care company:____

Insurance Company____

Ins. Address____City_________________________St________Zip__________

Claim #____________________________________Policy #__________________________________Group #___________________________

Adjuster/Case Manager____Phone_________________________________EXT__________

MEDPAY/UNINSURED MOTORIST COVERAGE

Insured's Name____________________ ___________________________ Insured's Relationship____________________________________

Insured's Date of Birth________________________________Insured's Soc. Sec. #____

Insured's Employer_________________________________Address____

Insurance Company____

Ins. Address____City_________________________St________Zip__________

Ins. Phone____________________________ Policy #________________________________ Group #____________________________

HEALTH INSURANCE: (Complete even if you are covered by auto insurance)

Insured's Name____________________ ___________________________ Insured's Relationship____________________________________

Insured's Date of Birth________________________________Insured's Soc. Sec. #____

Insured's Employer_________________________________Address____

Insurance Company____

Ins. Address____City_________________________St________Zip__________

Ins. Phone____________________________ Policy #________________________________ Group #____________________________

DENTAL INSURANCE:

Insured's Name____________________ ___________________________ Insured's Relationship____________________________________

Insured's Date of Birth___________________ Insured's SSN#________________________________ GROUP #________________________

Insurance Company____

Ins. Address____City_________________________St________Zip__________

Ins. Phone____________________________ Policy #________________________________ Group #____________________________

WORKERS COMPENSATION:

Employee____

Address____City______________________St_______Zip____________

Employer____________________________________Phone______________________Supervisor_________________________

Has accident been reported?____YES ____NO   Has treatment been authorized?____YES____NO   Claim #______________________

Insurance Carrier__________________________________Adjuster_____________________________Phone_________________

Ins. Address____City______________________St________Zip___________

Adjuster____Phone_____________________________EXT___________

ATTORNEY INFORMATION:

NAME OF FIRM:____

Attorney's Name____ Phone_____________________________________

Address____City______________________St________Zip___________

Are you currently negotiating a settlement regarding the accident?   _________YES   _________NO

REFERRAL:

Who can we thank for referring you to our office:

Name____ Phone_______________________________

Address____City_____________________St_______Zip____________

RELEASE: (Must be signed before treatment will be rendered)

I authorized the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I authorize and request my insurance company to pay directly to the dental/medical office insurance benefits otherwise payable to me. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

LATE CHARGES: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (within allowable law). I realize that failure to keep my account current may result in you being unable to provide additional services except for emergencies or where there is prepayment of additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

____   ___________________________

PATIENT OR GUARDIAN   DATE

____   ___________________________

PRINT NAME   WITNESS

II. ACCIDENT, HEAD/NECK TRAUMA HISTORY

IF YOU WERE INVOLVED IN AN ACCIDENT OR TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT______________________________TIME OF ACCIDENT OR INCIDENT_______________ AM/PM

WERE YOU?

_____A passenger in a vehicle?
_____The driver of a vehicle?
_____A pedestrian?
_____At work?
_____Did you fall?
_____Were you hit by an object?
_____Did you hit an object?
_____Other____

If in motor vehicle accident, were you wearing your seat belt? _____YES _____NO

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

_____At front end
_____At front left area
_____At rear end
_____At rear right area
_____At front right area
_____At left rear area

INDICATE IF THERE WAS ANY DIRECT TRAUMA:

DID YOUR:

_____Forehead
_____Face
_____Chin
_____Side of head
_____Back of head
_____Top of head
_____Teeth
_____Jaw
_____Other______________________________

FORCIBLY STRIKE:

_____Steering Wheel
_____Windshield
_____Passenger's side window
_____Driver's side window
_____Passenger's side door
_____Headrest
_____Seat
_____Roof
_____Other____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

_____Head
_____Neck
_____Face
_____Jaw
_____Teeth
_____Right shoulder
_____Left shoulder
_____Left arm
_____Right arm
_____Lower back
_____Upper back
_____Other____

BRIEFLY DESCRIBE THE ACCIDENT OR INCIDENT:

____

____

____

____

DID YOU GO TO THE HOSPITAL? ______YES ______NO BY CAR?_________ BY AMBULANCE?_________

WHICH HOSPITAL?____

WERE YOU RELEASED THE SAME DAY? ______YES ______NO CONFINED OVERNIGHT? ______YES ______NO

HAS A PHYSICIAN OR DENTIST EVER DIAGNOSED A TMJ DISORDER? ______YES ______NO
IF YES, PLEASE EXPLAIN:

____
____
____

WAS THIS DIAGNOSIS PRIOR TO THE ACCIDENT? ______YES ______NO
IF YES, PLEASE EXPLAIN:

____
____
____

PREVIOUS ACCIDENT AND/OR TRAUMA INFORMATION:

(You must complete this section if you have had a previous accident and/or trauma (prior to the accident/incident date listed above)

DATE OF PREVIOUS ACCIDENT_______________________________TIME OF PREVIOUS ACCIDENT___________________________

PLEASE GIVE AN ACCURATE DESCRIPTION:

____

____

____

____

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

(PLEASE PROVIDE COPIES OF BUSINESS CARDS FOR ALL HEALTH PROFESSIONALS)

1.Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

2. Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

3 Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

4. Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

5. Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

6. Practitioner:_________________________________Treatment:____
Address____ Phone________________________ Last Seen____________

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

(List in the order of importance, with #1 being most important)

1. ____ 6. ____

2. ____ 7. ____

3. ____ 8. ____

4. ____ 9. ____

5. ____ 10.____

III. MEDICAL HISTORY

DATE COMPLETED______________________________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

____

____

PLEASE ANSWER YES OR NO IF YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:
(You must check a YES or a NO on each item)

ALLERGIES:

Hay Fever _____YES _____NO
Food Allergies _____YES _____NO
Specify______________________________________
____
Other______________________________________

ARTHRITIS:

Gout _____YES _____NO
Osteoarthritis _____YES _____NO
Location:______________________________________
Rheumatoid Arthritis _____YES _____NO
Other______________________________________

ENDOCRINE DISORDERS:

Diabetes _____YES _____NO
Hypoglycemia _____YES _____NO
Parathyroid Disease _____YES _____NO
Thyroid Disease _____YES _____NO

EYE DISORDERS:

Glaucoma _____YES _____NO
Occular herpes _____YES _____NO
Other______________________________________

HIV ORDERS:

Aids _____YES _____NO
Tested HIV positive _____YES _____NO
Other______________________________________

KIDNEY/URINARY DISORDERS:

Sugar in Urine _____YES _____NO
Bladder Infections _____YES _____NO
Blood in Urine _____YES _____NO
Kidney Disease _____YES _____NO
Other______________________________________

ARTIFICIAL IMPLANTS:

Heart Pacemaker _____YES _____NO
Heart Valve _____YES _____NO
Joint Replacement _____YES _____NO
Specify Joint______________________________________
Other______________________________________

BLOOD DISORDERS:

Anemia _____YES _____NO
Bleeding Easily _____YES _____NO
Hemophilia _____YES _____NO
Leukemia _____YES _____NO
Sickle Cell Anemia _____YES _____NO
Other______________________________________

HEARTH/CIRCULATORY DISORDERS:

Arteriosclerosis _____YES _____NO
Congenital Hear Disorders-At Birth
_____YES _____NO
Heart Murmur _____YES _____NO
Heart Palpitations _____YES _____NO
High Blood Pressure _____YES _____NO
Low Blood Pressure _____YES _____NO
Poor Circulation _____YES _____NO
Rheumatic Fever _____YES _____NO
Other______________________________________

LIVER DISEASE:

Cirrhosis of the Liver _____YES _____NO
Hepatitis A (Infectious) _____YES _____NO
Hepatitis B (Serum) _____YES _____NO
Other______________________________________

LUNG/RESPIRATORY DISORDERS:

Asthma	_____YES	_____NO
Chronic Colds	_____YES	_____NO
Emphysema	_____YES	_____NO
Frequent Cough	_____YES	_____NO
Shortness of Breath	_____YES	_____NO

Other____

STOMACH/INTESTINAL DISORDERS:

Frequent Gas	_____YES	_____NO
Frequent Diarrhea	_____YES	_____NO
Bloating	_____YES	_____NO
Colitis	_____YES	_____NO
Constipation	_____YES	_____NO

Other____

IV. DENTAL HISTORY

YES	NO	
_____	_____	Do have missing back teeth?
_____	_____	Do you wear a removable partial denture?
_____	_____	Do you have extensive dental crowns and bridges?
_____	_____	Have you ever had orthodontic treatment?
_____	_____	Have you ever had you teeth equilibrated?
_____	_____	Have you had your third molars (wisdom teeth) removed?
_____	_____	Have you ever had a lengthy dental appointment? How long?___________________________
_____	_____	Have you ever had endodontic therapy? When?___________________________

What was the date of your last dental visit?____

Name of the dentist:____

_____ _____ Do you wear or have you ever worn a splint, bite plate, night guard, or appliance?

_____ _____ Have you ever been treated for problems with your jaw joints or for facial muscle spasms?

When?____

JAW RELATED CONDITIONS:

L	R	B	**(L: left, R:right, B:both sides)**
___________	___________	___________	Jaw Pain on Opening
___________	___________	___________	Jaw Pain on Wide Opening
___________	___________	___________	Jaw Pain on Side to Side Movement
___________	___________	___________	Jaw Pain on Closing
___________	___________	___________	Jaw Pain while Chewing
___________	___________	___________	Jaw Pain at Rest (Without Provocation)
___________	___________	___________	Jaw Clicks when Opening Mouth
___________	___________	___________	Jaw Clicks when Closing Mouth
___________	___________	___________	Sinus Pain

ANSWER YES OR NO TO THE FOLLOWING:

Jaw Pops	_____YES	_____NO
Jaw goes to Left when Opening	_____YES	_____NO
Jaw goes to Right when Opening	_____YES	_____NO
Jaw locks Closed	_____YES	_____NO
Jaw Locks Open	_____YES	_____NO
Inability to Move Jaw to the Left	_____YES	_____NO
Inability to Move Jaw to the Right	_____YES	_____NO
Clench Teeth during the daytime	_____YES	_____NO
Clench Teeth during the Nighttime	_____YES	_____NO
Grind Teeth during the Day	_____YES	_____NO
Grind Teeth during the Nighttime	_____YES	_____NO

PLEASE ANSWER YES OR NO IF YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING: (You must check a YES or a NO on each item)

EYE RELATED CONDITIIONS:

Blurred Vision _____YES _____NO
Double Vision _____YES _____NO
Lacrimation (Excessive Watering) _____YES _____NO
Opthalmic Migraine _____YES _____NO
Other_____________________________________

Pain or Pressure Behind Eyes _____YES _____NO
Photophobia (Extreme Sensitivity to Light _____YES _____NO
Swelling Below the Eyes _____YES _____NO
Pain in the Eyes _____YES _____NO

EAR RELATED CONDITIONS:

Buzzing in the Ears _____YES _____NO
Congestion/Stuffiness _____YES _____NO
Dizziness _____YES _____NO
Earache – Right Side _____YES _____NO
Earache – Left Side _____YES _____NO
Excessive Wax Production _____YES _____NO
Hearing Loss – Right Side _____YES _____NO
Hearing Loss – Left Side _____YES _____NO
Other_____________________________________

Meniere's Disease _____YES _____NO
Pain Deep Inside Ear _____YES _____NO
Pain in Front of Ear _____YES _____NO
Pain Behind Ear _____YES _____NO
Recurrent Infections _____YES _____NO
Tinitus (Ringing or Roaring in the Ear _____YES _____NO
Itching in the ears _____YES _____NO

MUSCLE DISORDERS:

Muscular Dystrophy _____YES _____NO
Muscle Shaking (Tremors) _____YES _____NO
Muscle Spasms or Cramps _____YES _____NO
Other_____________________________________

NERVE DISORDERS:

Cerebral Palsy _____YES _____NO
Epilepsy _____YES _____NO
Neuralgia _____YES _____NO
Multiple Sclerosis _____YES _____NO
Parkinson's Disease _____YES _____NO
Stroke _____YES _____NO
Other_____________________________________

NECK AND BACK RELATED CONDITIONS:

Back Pain (Lower) _____YES _____NO
Back Pain (Middle) _____YES _____NO
Back Pain (Upper) _____YES _____NO
Back Pain Radiating to Neck _____YES _____NO
Constant Feeling of Foreign Object in the Throat _____YES _____NO
Shoulder Pain (Right) _____YES _____NO
Shoulder Pain (Left) _____YES _____NO
Tightness in Throat _____YES _____NO
Neck Pain (Right) _____YES _____NO
Neck Pain (Left) _____YES _____NO
Limited Movement of Neck _____YES _____NO
Other_____________________________________

Constant Sore Throat _____YES _____NO
Difficulty in Swallowing _____YES _____NO
Scoliosis _____YES _____NO
Sciatica _____YES _____NO
Swelling in the Neck (Right) _____YES _____NO
Swelling in the Neck (Left) _____YES _____NO
Swollen Lymph Nodes (Right) _____YES _____NO
Swollen Lymph Nodes (Left) _____YES _____NO
Thyroid Enlargement _____YES _____NO
Wryneck _____YES _____NO
Numbness/Tingling in Hands or Fingers (Right) _____YES _____NO
Numbness/Tingling in Hands or Fingers (Left) _____YES _____NO

OTHER CONDITIONS:

Frequently Irritable _____YES _____NO
Chronic Fatigue _____YES _____NO
Cold Hands and Feet _____YES _____NO
Depression _____YES _____NO
Excessive Thirst _____YES _____NO
Fluid Retention _____YES _____NO
Frequent Stressful Situations _____YES _____NO
Frequently Ill _____YES _____NO
Swollen, Stiff of Painful Joints _____YES _____NO
Slow Healing Sores _____YES _____NO
Chemotherapy _____YES _____NO
Tumors _____YES _____NO
Use Extra Pillows to Help Breathing _____YES _____NO

Ovarian Cysts _____YES _____NO

History of Alcohol Abuse _____YES _____NO
History of Substance Abuse _____YES _____NO
Insomnia _____YES _____NO
Nervousness _____YES _____NO
Osteoporosis _____YES _____NO
Psychiatric Care _____YES _____NO
Radiation Treatment _____YES _____NO
Scarlet Fever _____YES _____NO
Skin Condition _____YES _____NO
Tired Muscles _____YES _____NO
Trouble Concentrating _____YES _____NO
Yeast Infections _____YES _____NO
Other_______________________________________

WOMEN:
Currently Pregnant _____YES _____NO
Anticipating Becoming Pregnant _____YES _____NO
Menstrual Cramps _____YES _____NO

V. SIGNS AND SYMPTOMS

SIGNS:

YES **NO**

_____ _____ Are you aware of clenching your teeth during the day?
_____ _____ Do you ever awaken with an awareness of your teeth or jaws?
_____ _____ Have you ever been told that you grind your teeth in your sleep?
_____ _____ Do your teeth hurt from clenching or biting?
_____ _____ Do you have any pain or soreness around your eyes, ears or other parts of your face?
_____ _____ Do you have difficulty hearing:
_____ _____ Do you have ‘tension” headaches?
_____ _____ Do you have occasional headaches?
_____ _____ Have you ever been diagnosed as having migraine headaches? When?_________________________________
_____ _____ Do you frequently have stiff neck muscles or neck aches?
_____ _____ Do your jaw muscles become tired frequently?
_____ _____ Do you have difficulty in opening your mouth widely?
_____ _____ Does any family member have arthritis or gout? Who?____
_____ _____ Have you ever received a severe blow to the face or jaw? Explain:_______________________________________
____
____

YES **NO**

_____ _____ Have you ever had pain in your jaw joint? When?____
_____ _____ Have you ever had problems with your ears, such as ringing or change of hearing?
_____ _____ Do you ever hear grating or grinding sounds from your jaw joints?]
_____ _____ Do you ever hear clicking or popping sounds from your jaw joints?
_____ _____ Are you presently in any pain from your jaw joints or muscles?
_____ _____ Does pain or discomfort from your jaw joint interfere with you work or other activities?
_____ _____ Are there time when you notice that this problem or pain is less or gone completely?
_____ _____ Do you feel depressed?
_____ _____ Have you ever seen a psychologist or psychiatrist for treatment?
_____ _____ Do you have a problem with insomnia?
_____ _____ Are you under a great deal of stress? _____Job _____Work _____Family _____Other (Please explain_____
____
_____ _____ Do you take more than one alcoholic drink per day?
_____ _____ Do you smoke cigarettes, cigars or a pipe? _______packs per day
_____ _____ Do you bite your nails, tongue or lips?
_____ _____ Do you feel your pain is related to stress?

SYMPTOMS:

HEAD PAIN:

LOCATION L	R	B	(L:left, R:right, B:both Sides)	SEVERITY Mild	Mod.	Severe	FREQUENCY Occasional	Frequent	Constant	DURATION Sec.	Min.	Hrs.	Days	Wks
___	___	___	Front of your Head (Frontal)	___	___	___	____	____	____	___	___	___	___	___
___	___	___	Entire Head (Generalized)	___	___	___	____	____	____	___	___	___	___	___
___	___	___	Top of your head (Parietal)	___	___	___	____	____	____	___	___	___	___	___
___	___	___	Back of your head (Occipital)	___	___	___	____	____	____	___	___	___	___	___
___	___	___	In your Temples (Temporal)	___	___	___	____	____	____	___	___	___	___	___
___	___	___	Facial (Face)	___	___	___	____	____	____	___	___	___	___	__

MOUTH AND NOSE RELATED CONDITIONS:

Broken teeth _____YES _____NO (#'s)____

Burning tongue _____YES _____NO
Chronic sinusitis _____YES _____NO
Dry mouth _____YES _____NO
Have had general Anesthesia _____YES _____NO
Tendency to snore _____YES _____NO
Frequent biting of cheek _____YES _____NO

Other ____

OTHER CONDITIONS:

Recent change in lifestyle _____YES _____NO
Recent change in work pattern _____YES _____NO
Other____

SYMPTOMS ARE WORSE:

Upon rising in the morning _____YES _____NO
At end of each day _____YES _____NO
Midmorning _____YES _____NO
After talking _____YES _____NO
During menstrual period _____YES _____NO
When under stress _____YES _____NO
After yawning _____YES _____NO
After eating _____YES _____NO
At work _____YES _____NO
At home _____YES _____NO
At school _____YES _____NO
Other____

WHAT OTHER INFORMATION IS IMPORTANT TO YOUR CONDITION?

____

____

____

____

Revised 8-26-03