PATIENT INFORMATION RECORD (Page 1)

Date _____

Patient's Name _____
Last First Middle

Home Address _____
Street City State Zip

Home Phone _____ Date of Birth _____ Age _____

Cell Phone _____ Patient Social Security No. _____

Work Phone _____ Patient Employed By _____

E-Mail_____ Marital Status: Patient_____Parents_____

Spouse or Father's Name _____ Mother's Name _____

Spouse or Father's Birthday _____ Mother's Birthday_____

Spouse/Father's Social Security No._____ Mother's Social Security No._____

Spouse/Father Employed By _____ Mother Employed By _____

Spouse/Father Work Phone _____ Mother Work Phone _____

Spouse/Father Occupation _____ Mother Occupation _____

Referring Doctor or Person

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

E-Mail _____

Closest Relative Not Living With You.

Name _____Relation_____

Address_____

City _____State_____ ZIP _____

Phone _____

Primary Insurance Company

Medicaid or Medicare? Number _____

Name _____ Policy Holder _____

Address _____ Group Number _____

City _____ State_____Zip _____ Policy Number _____

Phone Number _____

HEALTH QUESTIONNAIRE **YES** **NO**

1. Do you have difficulty breathing or was your nose ever injured? _____ _____
2. Within the past 5 years, have you had any illness requiring care by a physician or surgeon? _____ _____

   Please list the illness? _____

   _____

3. Have you had any surgery? If so, please list _____ _____

   _____

   _____

PATIENT INFORMATION RECORD (page 2)

	YES	NO
4. Do you ever have pain in your chest while at rest?	_____	_____
With exertion or exercise?	_____	_____
5. Have you ever had a heart attack, heart failure, or other heart trouble?	_____	_____
6. Do your ankles ever swell?	_____	_____
7. Do you ever get short of breath or winded?	_____	_____
8. Do you smoke?	_____	_____

a. How much? _____ b. How long? _____

9. Do you have or ever had high blood pressure? What is your pressure?_____	_____	_____
10. Have you ever had abnormal bleeding associated with dental extractions, surgery, or trauma?	_____	_____

11. How much do you weigh? _____ How tall are you? _____

12. Women: Are you pregnant?	_____	_____

13. Please **CIRCLE** any of the following which you have had had: (if none, circle NONE), and sign in space below:

allergy	tuberculosis	venereal disease
sinus trouble or stuffed up nose	heart burn	thyroid disease
asthma or hay fever	lung disease	liver trouble
hives or skin rash	glaucoma	porphyria
fainting spells	nervous problems	anemia
epilepsy or seizure	arthritis	kidney trouble
hepatitis, jaundice, or liver disease	stomach ulcers or diarrhea	Bleeding disorder
rheumatism or painful swollen joints	AIDS	**NONE OF THE ABOVE**

Other Diseases_____ Signature _____Date_____

14. List any medication and dosages you are taking: _____

_____ _____

_____ _____

15. Do you have any allergies or have you ever reacted adversely to any medication, food, or other substances? Please list.

_____

_____

16. Name, address & phone # of your Orthodontist

_____

_____

_____

_____

Name, address and phone # of your general dentist

_____

_____

_____

_____

17. Name, address & phone # of your Medical Doctor(s)

_____

_____

_____

Questionnaire

NAME: _____ AGE: _____ DATE: _____

List your concerns and problems:

What do you want Treatment to accomplish for you?

List all Medications you are taking:

List all other Medical Conditions you have:

List all TMJ Surgery and Treatments you have had (include dates):
(i.e., orthodontics, splints, physical therapy, etc.)

List all other Surgeries you have had, excluding the TMJ (include dates):

TMJ Questionnaire

NAME: _____ AGE: _____ DATE: _____

Do you have jaw joint (TMJ) pain? No ____; Yes ____ Is the pain: Mild ____; Moderate ____; Severe ____?

Do you have TMJ noises when you open and close your mouth? No ____; Yes ____
Are the noises: Clicking ____; Popping ____; Grinding ____? Are the noises: Mild ____; Moderate ____; Severe ____?

Is the pain in the TMJ on the: Left ____; Right ____? Are the TMJ noises on the: Left ____; Right ____?

When did your jaw joint problems (i.e., pain, noises, headache) begin? Age _____; Year _____
What started your jaw joint problems? Injury ____; Disease ____; Unknown _____

Explain: _____

Have you had previous TMJ surgery? No ____; Yes ____ How many operations? Right TMJ ____; Left TMJ ____
Have your jaw alignment or bite changed? No ____; Yes ____ How much change? Mild ____; Moderate ____; Severe ____

Do you get headaches? No ____; Yes ____ Are the headaches: Mild ____; Moderate ____; Severe ____?
Are your headaches worse in the: Morning ____; Afternoon ____; Evening ____; Night ____; No Difference ____?
How many headaches do you get a week ____; a month ____? Are they: Occasional ____; Frequent ____; Constant ____?

Where do the headaches occur? Left Forehead ____; Right Forehead ____; Left Temple ____; Right Temple ____;
Back of the Head ____; Top of Head ____; Behind Left Eye ____; Behind Right Eye ____

Do you have: Neck ____; Shoulder ____; or Back pain ____? Is the pain: Mild ____; Moderate ____; Severe ____?

Do you clench ____ and/or grind ____ your teeth at night? No ____; Yes ____; During the day? No ____; Yes ____
Is your clenching/grinding: Mild ____; Moderate ____; Severe ____?

Do you get earaches? No ____; Yes ____ On which side? Left ____; Right ____
Are they: Mild ____; Moderate ____; Severe ____?
Do they occur: Occasionally ____; Moderately ____; Frequently ____; Continuously ____?

Do you get ringing in your ears? No ____; Yes ____: Is the ringing: Mild ____; Moderate ____; Severe ____?
Does it occur: Occasionally ____; Moderately ____; Frequently ____; Continuously ____?

Do you get lightheadedness or dizziness? No ____; Yes ____: Is it: Mild ____; Moderate ____; Severe ____?
Does it occur: Occasionally ____; Moderately ____; Frequently ____; Continuously ____?

Do you suffer from depression? No ____; Yes ____ Are you under treatment for depression? No ____; Yes ____
Do you have problems with other joints? No ____; Yes ____ Please list the other joints: _____

Circle the number that best describes your situation

TMJ pain (No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Headache (No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Average daily pain for head and neck area (No pain) 0—1—2—3—4—5—6—7—8—9—10 (Worse Pain Imaginable)

Rate your jaw function for opening, side to side movement, and chewing Normal Function 0—1—2—3—4—5—6—7—8—9—10 No Function; Jaws Frozen

What can you chew? No Restriction Chew Anything 0—1—2—3—4—5—6—7—8—9—10 Liquids Only Cannot Chew

How much does your jaw problem affect your ability to carry out normal life activities? No Interference In Any Way 0—1—2—3—4—5—6—7—8—9—10 Totally Disabled

Airway Questionnaire

NAME: _____ AGE: _____ DATE: _____

Do you breathe through your mouth during the day? No ____; Yes____
What is you breathing difficulty : Mild____; Moderate____; Severe____?

Do you breathe through your mouth when you sleep? No____; Yes____
Does this occur: Occasionally ____; Moderately ____; Always ____?

Do you breathe through your mouth during the day? No____; Yes____
Does this occur: Occasionally ____; Moderately ____; Always ____?

Do you snore? No ____; Yes ____ Is your snoring: Mild ____; Moderate ____; Severe ____?

Are you tired during the day? No ____; Yes ____
Is your daytime tiredness: Mild ____; Moderate ____; Severe ____?

Do you have Sleep Apnea? No ____; Yes ____; When did it start or was diagnosed?_____
Is your Sleep Apnea: Mild ____; Moderate ____; Severe ____?

Do you have difficulties sleeping at night? No ____; Yes ____
Are your sleep difficulties: Mild ____; Moderate ____; Severe ____?

Do you toss and turn a lot when sleeping? No ____; Yes ____
Is the tossing and turning: Mild ____; Moderate ____; Severe ____?

Do you wake up at night unable to catch your breath? No ____; Yes ____
Does this occur: Occasionally ____; Moderately ____; Frequently ____?

Do your legs and/or arms jerk at night? No ____; Yes ____
Is the leg and arm jerking: Mild ____; Moderate ____; Severe ____?

Do you sleep on your: Back ____; Sides ____; Stomach ____; Other _____?

Do you have high blood pressure? No ____; Yes ____
Is it: Mild____; Moderate ____; Severe ____? What is your blood pressure? _____

Do you smoke? No ____; Yes ____; Packs per day ____; Cigarettes per day ____; Other _____
Number of Years ____. Any lung (pulmonary) conditions? No ____; Yes ____

What are the conditions? _____

Have you had surgery for your breathing or Sleep Apnea conditions? No ____; Yes ____

What procedures have been done? _____

_____

Have you had a Sleep Study? No ____; Yes ____ (If yes, please send copy of report)