

# Center For Family & Cosmetic Dentistry

1 East Campus View Blvd.  
Columbus, Ohio 43235  
(614) 848-5001 - Fax: (614) 848-5003

## PATIENT INFORMATION

MR    MRS    DR    MS    MISS |  MARRIED    SINGLE    DIVORCED    WIDOWED

PATIENT'S NAME \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  MALE    FEMALE

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ E-Mail Address \_\_\_\_\_

HOW LONG AT PRESENT ADDRESS? \_\_\_\_\_

IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.

PREVIOUS ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

### **IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE BOX BELOW**

PARENT    GUARDIAN   NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOW LONG AT PRESENT ADDRESS? \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

\_\_\_\_\_

**INSURANCE INFORMATION** We will gladly provide you with an insurance claim form and any necessary information for each visit. It is your responsibility to send your claim to your insurance company and follow up for payment. Please let us know if you have any questions.

INSURANCE COMPANY \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

INSURED'S DATE OF BIRTH \_\_\_\_\_

**We are a "fee for service" office and require payment at the time of service. Our returned check fee is \$50.**

*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES, please explain on the line provided.

## MEDICAL HISTORY:

1. YES NO Do you have a current medical problem? \_\_\_\_\_
2. YES NO Have you been told you have a heart murmur? \_\_\_\_\_
3. YES NO Do you have any heart problems? What kind? \_\_\_\_\_
4. YES NO Do you have  High or  Low Blood Pressure? Is it controlled?  YES  NO
5. YES NO Have you had rheumatic fever? When \_\_\_\_\_
6. YES NO Have you had pain in your chest or shortness of breath? \_\_\_\_\_
7. YES NO Do your ankles swell? \_\_\_\_\_
8. YES NO Has your physician ever told you that you are anemic? \_\_\_\_\_
9. YES NO Have you ever had a stroke? When? \_\_\_\_\_
10. YES NO Have you ever had epilepsy? \_\_\_\_\_
11. YES NO Do you have diabetes? Is it controlled? \_\_\_\_\_
12. YES NO Do you have fainting or dizzy spells? \_\_\_\_\_
13. YES NO Do you feel like your sense of balance has changed? \_\_\_\_\_
14. YES NO Do you have headaches? How often? Where? \_\_\_\_\_
15. YES NO Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? \_\_\_\_\_
16. YES NO Have you been advised not to take any medication? What? \_\_\_\_\_
17. YES NO Do you have asthma or hay fever? How is it controlled? \_\_\_\_\_
18. YES NO Have you ever had tuberculosis? When? \_\_\_\_\_
19. YES NO Have you ever had glaucoma? When? \_\_\_\_\_
20. YES NO Have you ever had hepatitis? When? \_\_\_\_\_
21. YES NO Do you have arthritis? How is it controlled? \_\_\_\_\_
22. YES NO Have you ever had a tumor or cancer? How was it treated? \_\_\_\_\_
23. YES NO Have you ever had any major surgeries? What kind? \_\_\_\_\_
24. YES NO Have you ever been injured in an accident? When? \_\_\_\_\_
25. YES NO Have you ever had a severe blow to the head? When? \_\_\_\_\_
26. YES NO Are your hands and/or feet cold? How often? \_\_\_\_\_
27. YES NO Is your diet medically supervised? For what purpose? \_\_\_\_\_
28. YES NO Do you have difficulty swallowing? \_\_\_\_\_
29. YES NO Do you have a feeling of something stuck in your throat? \_\_\_\_\_
30. YES NO Do you ever have any facial pain or pressure? Where? \_\_\_\_\_
31. YES NO Do you ever have any pain or pressure behind your eyes? \_\_\_\_\_
32. YES NO Are you aware of stiff neck muscles? How often? \_\_\_\_\_
33. YES NO Have you been in traction for a neck injury? When? \_\_\_\_\_
34. YES NO Have you ever had or been advised to have neck surgery? \_\_\_\_\_
35. YES NO Do you have back pain? Where? \_\_\_\_\_
36. YES NO Do your ears feel itchy, stuffy or congested? \_\_\_\_\_
37. YES NO Do you have difficulty with pain in your ears when changing altitude? \_\_\_\_\_
38. YES NO Do your ears ring, buzz or hiss? How often? \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

- 39. YES NO Have you noticed any changes in your hearing? \_\_\_\_\_
- 40. YES NO Are you depressed? \_\_\_\_\_
- 41. YES NO Do you have emotional or anxiety/nervous problems? \_\_\_\_\_
- 42. YES NO Have you ever been treated for emotional or anxiety/nervous problems? \_\_\_\_\_
- 43. YES NO Have you  gained or  lost weight within the last year? How much? \_\_\_\_\_
- 44. YES NO Do you take more than one alcoholic drink per day? How many? \_\_\_\_\_
- 45. YES NO Do you use tobacco? How much? \_\_\_\_\_
- 46. YES NO Have you had any other serious illnesses, hospitalization or accidents? \_\_\_\_\_

Please explain: \_\_\_\_\_

Please list ALL medications and the dosage you are currently taking:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Please list any allergies to any **medications**:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Other allergies:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**DENTAL HISTORY:**

- 47. YES NO When was your last dental visit? \_\_\_\_\_
- 48. YES NO Have you been told that you have periodontal (gum) disease? \_\_\_\_\_
- 49. YES NO Do you have any existing problems with your teeth? Describe \_\_\_\_\_
- 50. YES NO Is any dental treatment planned? Describe \_\_\_\_\_
- 51. YES NO Do you bite your nails? \_\_\_\_\_
- 52. YES NO Have you ever had oral surgery? \_\_\_\_\_
- 53. YES NO Have you lost any teeth? From what cause? \_\_\_\_\_
- 54. YES NO Have the teeth been replaced? When? \_\_\_\_\_
- 55. YES NO Have you ever had orthodontic treatment? When? \_\_\_\_\_
- 56. YES NO Have you ever had extensive dental treatment? When? \_\_\_\_\_
- 57. YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?  
Where? \_\_\_\_\_
- 58. YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO

**TMJ HISTORY**

- 59. YES NO Do you ever have a burning or painful sensation in your mouth? \_\_\_\_\_
- 60. YES NO Do you get popping, clicking, or grinding noises when you open or close? \_\_\_\_\_
- 61. YES NO Do you ever awaken with an awareness of your teeth or jaws? \_\_\_\_\_
- 62. YES NO Are you aware of clenching during the daytime? How often? \_\_\_\_\_
- 63. YES NO Have you ever been told you grind your teeth during sleep? \_\_\_\_\_
- 64. YES NO Do you have trouble opening your mouth widely? \_\_\_\_\_
- 65. YES NO Does your jaw ever lock open or closed? How often? \_\_\_\_\_
- 66. YES NO Do you feel your bite is different, unstable or uncomfortable? \_\_\_\_\_
- 67. What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? \_\_\_\_\_
- 68. YES NO If you sought treatment for a TMJ problem, did it help? \_\_\_\_\_
- 69. YES NO Do you or have you had any pain in any of the following areas? (circle)  
Jaw Ear Face Neck Teeth Head Other \_\_\_\_\_
- 70. YES NO Do your jaw problems affect your ability to chew? \_\_\_\_\_
- 71. YES NO Has your diet changed due to your jaw problems? Describe \_\_\_\_\_
- 72. YES NO Do your joint noises affect others while eating? \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FAMILY HISTORY:**

- 73. YES NO Do you have children. What are their ages? \_\_\_\_\_
- 74. YES NO Does your partner help you? \_\_\_\_\_
- 75. YES NO Do you have house guests? \_\_\_\_\_
- 76. YES NO Does your job satisfy you? \_\_\_\_\_

**FOR WOMEN:**

- 77. YES NO Are you pregnant? Expected delivery date? \_\_\_\_\_
- 78. YES NO Do you have a history of miscarriages? When? \_\_\_\_\_
- 79. YES NO Have you reached menopause? \_\_\_\_\_

**SLEEP, SNORING AND APNEA HISTORY**

- 80. YES NO Do you become easily fatigued? At what time of day? \_\_\_\_\_
- 81. YES NO Do you have problems with insomnia? \_\_\_\_\_
- 82. YES NO Do you sleep well? How long? \_\_\_\_\_
- 83. YES NO Do you dream? How often? \_\_\_\_\_
- 84. YES NO Do you have trouble falling asleep or staying asleep? Which \_\_\_\_\_
- 85. YES NO Do you snore or have you been told you do? \_\_\_\_\_
- 86. YES NO Do you wake up with a headache? \_\_\_\_\_
- 87. YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain? \_\_\_\_\_
- 88. YES NO Do you often fall asleep reading or watching television? \_\_\_\_\_
- 89. YES NO Have you fallen asleep during the day against your will? \_\_\_\_\_
- 90. YES NO Have you had to pull off the road while driving due to sleepiness? \_\_\_\_\_
- 91. YES NO Have you been more irritable and short tempered? \_\_\_\_\_
- 92. YES NO Have you felt that your memory and/or intellect is impaired? \_\_\_\_\_
- 93. YES NO Have you been told that you stop breathing while asleep? \_\_\_\_\_
- 94. About how many times per night do you wake up? \_\_\_\_\_
- 95. What time do you normally go to bed? \_\_\_\_\_ Get up in the morning? \_\_\_\_\_
- 96. Of the hours you are in bed, about how many hours are you asleep? \_\_\_\_\_
- 97. Would you rate the quality of your sleep as  Good  Fair  Poor?
- 98. YES NO Do you have difficulty breathing through your nose? \_\_\_\_\_
- 99. Present body weight: \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ inches.
- 100. YES NO Have you been diagnosed or treated for a sleep disorder? When \_\_\_\_\_
- 101. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder?
- 102. YES NO Have you ever had an evaluation at a sleep center?

Sleep Center Name: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 Sleep Study Date: \_\_\_\_\_

- 103. What professional advice or treatment have you received about your snoring or sleep apnea?  
 \_\_\_\_\_  
 \_\_\_\_\_
- 104. YES NO If you sought treatment for a sleep disorder, did it help? \_\_\_\_\_  
 \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

*This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.*

**Use the following scale and choose the most appropriate number for each situation:**

Sitting and reading _____	0 = Would <b>never</b> doze
Watching TV _____	1 = <b>Slight</b> chance of dozing
Sitting inactive in a public place (e.g. A theater or a meeting) _____	2 = <b>Moderate</b> chance of dozing
As a passenger in a car for an hour without a break _____	3 = <b>High</b> chance of dozing
Lying down to rest in the afternoon when circumstances permit _____	
Sitting and talking to someone _____	
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in traffic _____	

### **IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION AND TURN THE PAGE!**

#### **CPAP HISTORY:**

YES NO Do you wear a CPAP device **successfully** during sleeping?

How many hours per night do you wear your CPAP? \_\_\_\_\_

YES NO Have you tried other therapies for your sleeping disorder?

Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.) \_\_\_\_\_

**If you are unable to wear a CPAP device, please check below reasons for your difficulty.**

- Mask Leaks
- Mask Uncomfortable/Device Uncomfortable
- Unable to sleep comfortably
- Noise disturbs my sleep and/or bed partner's sleep
- Restricts movement during sleep
- Does not seem to be effective
- Straps/headgear cause discomfort
- Pressure on the upper lip causes tooth related problems
- Latex Allergy
- Claustrophobia
- Other \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

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

<p style="text-align: center;"><b><u>ORDER</u></b></p> <p>1. Please order your <i>chief complaints</i> by number:                  #1 being the 1<sup>st</sup> or <u>most</u> important,                  #2 the 2<sup>nd</sup> important,                  #3 the 3<sup>rd</sup> less important,                  #4, #5, #6, etc.                  (List all please)</p> <p style="text-align: right;">➔</p>	<p style="text-align: center;"><b><u>FREQUENCY</u></b></p> <p>2. Rate your chief complaints for frequency as follows:                  1= Seldom                  2= Occasional                  3= Frequent                  4= Every Day</p> <p style="text-align: center;">↓</p>	<p style="text-align: center;"><b><u>INTENSITY</u></b></p> <p>3. Rate the intensity of each complaint ordered on a scale from 0-10.                  0= No Pain to                  10= Most severe pain</p> <p style="text-align: right;">↙</p>
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<u>Chief Complaint</u>	<u>ORDER</u>	<u>Frequency</u> (1-4)	<u>Intensity</u> 0-10	<i>For Office Use Only</i>
Jaw clicking/popping	_____	_____	_____	_____
Jaw joint noises	_____	_____	_____	_____
Jaw locking	_____	_____	_____	_____
Muscle twitching	_____	_____	_____	_____
Limited mouth opening	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Visual disturbances	_____	_____	_____	_____
Jaw pain	_____	_____	_____	_____
Facial pain	_____	_____	_____	_____
Ear pain	_____	_____	_____	_____
Back pain	_____	_____	_____	_____
Eye pain	_____	_____	_____	_____
Neck pain	_____	_____	_____	_____
Shoulder pain	_____	_____	_____	_____
Pain when chewing	_____	_____	_____	_____
Throat pain	_____	_____	_____	_____
Ear congestion	_____	_____	_____	_____
Sinus congestion	_____	_____	_____	_____
Ringling in the ears	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Frequent heavy snoring	_____	_____	_____	_____
Snoring which affecting sleep of others	_____	_____	_____	_____
Significant daytime drowsiness	_____	_____	_____	_____
Stop breathing when sleeping	_____	_____	_____	_____
Difficulty falling asleep	_____	_____	_____	_____
Gasping when waking up	_____	_____	_____	_____
Nighttime choking spells	_____	_____	_____	_____
Feeling unrefreshed upon waking	_____	_____	_____	_____
Morning hoarseness	_____	_____	_____	_____
Swelling in ankles or feet	_____	_____	_____	_____
Other	_____	_____	_____	_____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

When did your symptoms first start?

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Was there a specific incident, accident or injury that seemed to trigger your symptoms?

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Do your present symptoms affect relationships with family and friends? If so, how?

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What are your expectations in seeking treatment at this time?

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What do you see yourself doing, after treatment that you are not able to do now?

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**ATTORNEY INFORMATION**

**Are you involved in a lawsuit regarding your condition?**     Yes     No

If you have an attorney representing you, please complete the following:

Attorney's Name \_\_\_\_\_

Paralegal \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire.

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*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Please take a moment to read our office policies and feel free to ask any questions you may have.

**CONSENT FOR TREATMENT**

I hereby authorize the TMJ Therapy and Sleep Center and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize the TMJ Therapy and Sleep Center and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated on the following page. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

**FINANCIAL POLICY**

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, check, MasterCard/Visa and Discover. For our patients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Patient Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 1.5% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. I understand that a credit history may be secured. Our returned check fee is \$25.

Our goal is to eliminate "billing surprises" so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

**APPOINTMENTS**

Should you need to cancel an appointment, we ask that you notify our office at least 24 hours in advance. If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you will be charged a broken appointment fee of \$75.

I have read and understand the TMJ Therapy and Sleep Center Consent for Treatment, Financial and Appointment policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.	
Patient Signature: _____	Date: _____
Parent/ Responsible Party Signature: _____	Date: _____
Relationship: _____	Witness: _____



To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. ***Please initial*** if you want us to send them a report from your visit.

*Initial* FAMILY PHYSICIAN

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* DENTIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* CHIROPRACTOR

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PHYSICAL THERAPIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* ENT

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* CARDIOLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* ALLERGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* NEUROLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PSYCHIATRIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PSYCHOLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* SLEEP SPECIALIST

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

*Initial* OTHER

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

- I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.
- I do not wish to have my records sent at this time.

*I certify that the above information is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_