



| | | | |
|-----------------|-------------|-------------|-------------------------|
| PATIENT: | | ADDRESS: | |
| HOME TELEPHONE: | WORK PHONE: | CITY | STATE ZIP |
| OCCUPATION: | | BIRTH DATE: | SOCIAL SECURITY NUMBER: |

Regular Doctor or Health Care Provider _____ Regular Dentist _____

What medications are you currently taking? _____

Describe in your own words what brings you here _____

When did your symptoms begin? _____ How do they interfere with your normal activities? _____

Are they due to an accident? Yes No Will Insurance related to the accident pay for treatment? Yes No

What treatment have you received? _____ How much did it help? _____

Do you need to set up a payment plan for treatment? Yes No Are you interested in physical therapy for symptomatic relief? Yes No

Whom may we thank for this referral? _____ Address _____ Phone _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- | | | |
|---|---|---|
| HIV..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Strong allergic reaction <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEADACHES

How often do you get headaches? _____ How do you know one is coming? _____

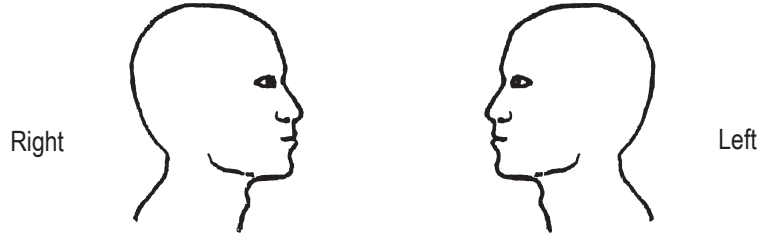
Anything effective at making them disappear? Yes No What treatment have you received for them? _____

PAIN

Draw your pain patterns following this key:

- |||| Mild Pain
- /// Moderate Pain
- ///// Severe Pain

- B Burning
- D Dull
- H Heavy Pressure
- N Numbing
- S Sharp
- T Tingling
- R Radiating



When did your pain begin? _____ When do you have it? _____

How would you describe it? _____

Does chewing or yawning make it worse? Yes No

POSTURE

Do you have chronically tight muscles? Where? _____ Soreness or pain behind the ears? Yes No

Do you get persistent soreness in the neck? Yes No Do you get chiropractic care? From Whom? _____

INTERNAL EAR AREA

Do your ears often feel stuffy, blocked, or itchy inside? Yes No

Do you hear ringing, roaring, or buzzing sounds in your ears? Yes No

So you have difficulty clearing them after altitude changes? Yes No

Do you sometimes have difficulty hearing? Yes No

Do you sometimes feel dizzy? When? _____

Do you sometimes feel like there is fluid in your ears? Yes No

How often do you get earaches? _____

Do you sometimes feel disoriented for no apparent reason? Yes No

THROAT JAW MUSCLES

Chronic feeling of a lump or foreign body in throat? Yes No Are you aware of clenching or grinding your teeth? Yes No
Do you get tired chewing tough foods? Yes No Do you gag easily? Yes No

DENTAL

Are you aware of any problems with your teeth? Yes No Do you sometimes feel like it's difficult to find your bite? Yes No
Have you had recent dental work that affected symptoms? Yes No Have you had orthodontic treatment in the past? Yes No
Have you ever had a crown or filling that felt too high? Yes No Have you ever worn a bite splint, nightguard, TMJ appliance? Yes No
Is it difficult or painful to bite down hard? Yes No Have you noticed any change in your bite? Yes No

TEMPOROMANDIBULAR JOINT

Do you hear clicking, popping, or grinding in jaw joints? Yes No Have you ever had pain / difficulty opening mouth wide? Yes No
When did you first notice it? _____ Do you sometimes feel like it's difficult to find your bite? Yes No
Has the sound changed in any way? Yes No Have you had orthodontic treatment in the past? Yes No
Have you ever worn a bite splint, nightguard, TMJ appliance? Yes No

JUST A LITTLE MORE

Do you get twitching, tics or tremors in the facial area? Yes No Do you wake up feeling refreshed? Yes No
Extreme sensitivity to light? Yes No What is your source of physical exercise? _____

FINANCIAL POLICY OF THE TMJ CLINIC, PC

We are proud of our success rate and we will use all of the latest knowledge in this field to help you. However you must understand that we cannot guarantee relief. If you are one of the few patients who do not respond well to treatment, we may be willing to put in extra time and effort to help you, but you are still responsible for payment of the bill.

If you have medical insurance, we may be willing to bill your medical insurance directly. However, any billing and negotiation we do with your insurance company is an extra service and not an obligation. Legally, our responsibility is only to document the medical necessity of your treatment. It is ultimately your responsibility to negotiate with your insurance company regarding payment of services.

If you have dental insurance, it may cover a portion of the treatment. For example, it may cover a nightguard to protect your teeth but not the custom made orthopedic portion which is added to the nightguard to protect your TMJ's. We will be willing to accept dental insurance as a partial payment of the treatment.

If you do not have either medical or dental insurance, you will need to pay for services at the time of your appointment. We will be willing to set up a payment plan if you are unable to pay in full at the time of service. If you are not able to keep your payment agreement, please contact our office because we will add an additional interest charge or 1.5% per month for unpaid balances. If it becomes necessary to pursue collections, you will be responsible for all of the fees incurred. We do offer a discount of 10% of service if you pay in full at the time of service.

Signature of patient (or guardian)

Date

Person to contact in case of emergency

address

phone