theTMJ doc | PRIYA MISTRY DDS

16415 SE 15th St. Ste. #103, Vancouver, WA 98683
Phone: (503)255-8293 / Fax: (503)252-1214
www.tmjdentaldoc.com

HELLO NEW PATIENT!

PLEASE FILL OUT **ALL FORMS** PRIOR TO YOUR APPOINTMENT

OUR OFFICE IS PROUD OF BEING ON TIME, AND WE ASK THE SAME OF OUR PATIENTS. ARRIVING LATE OR WITH INCOMPLETE FORMS MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED

THANK YOU IN ADVANCE FOR YOUR COOPERATION

DR. PRIYA MISTRY AND STAFF

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Your First Appointment:

Welcome to our clinic.

We are located at 16415 SE 15th St. Ste# 103 Vancouver, WA 98683

Call for assistance if you feel that would be helpful.

Please fill out your patient intake forms completely for us to review on your appointment, it's long but please take the time to read it thoroughly and fill it out. Please understand that this information when correlated with your examination will provide valuable information for an accurate diagnosis and appropriate treatment plan for your condition. If your history is long and complicated, I suggest you bring in a written chronology for us to review.

We have scheduled an hour for your first appointment. Once we have completed your diagnosis and discussed the most appropriate treatment for your condition, a fee can be established for that treatment. We will answer any and all questions at the time and then we will introduce you to our business manager who will review with you all costs and fees involved in your treatment, discuss your insurances benefits, and present all financial options we offer.

TMJ, or more often TMD, is considered to be a medical condition with number of appropriate diagnosis code that can be applied and submitted to your medical insurance company. Bring your insurance card with you and if you feel it necessary contact your company prior to your first appointment to determine the extent of your benefits; that could be helpful as your insurance is unlikely to pay for all of your treatment.

This office recognizes and appreciates the trust placed with us by accepting treatment at our clinic. We endeavor to be timely, open, and supportive for all our patients and strive to honor that trust by providing the highest quality for care that you require and deserve.

Sincerely,

Priya Mistry, DDS

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HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices prior* to signing this consent. I understand that this organizations has the right to change its *Notice of Privacy Practices* form time to time and that I may contact organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

Priya Mistry, DDS
16415 SE 15th St. Ste. #103
Vancouver, WA 98683

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and/or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

_____ _____

Signature of Patient and/or Legal Guardian Date

_____

Printed Name of Patient

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Consent Form

- A proper diagnosis regarding head and neck pain is very important because serious problems such as vascular disorders, brain tumors, cervical disc disorders, etc., can produce similar symptoms to TMJ disorders. An MRI of the brain, TMJ's and/or the neck is valuable in diagnosing these problems and you can request one from your medical doctor. It is important to inform our office of any changes in your health history form that previously provided.
- In order to achieve a successful outcome of your treatment, it is crucial that you make a commitment to keep all scheduled appointment and to remain in treatment until you are medically stationary. It had been our experience that most patients will achieve medical stability in 4-6 months from the time treatment begins.
- Length of treatment may vary according to the complexity of your condition. Treatment times, therefore, may vary from estimation. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits, bite relationships, etc., do affect the outcome, and total resolution is not always possible.
- The treatment methods we will use are based on our experience and knowledge to be the most proven, appropriate, cost-effective and conservative. However, you should be aware there is much debate in the medical- dental community regarding the best way to treat various TMJ disorders.
- If an appliance is used in your treatment, it is theoretically possible for the appliance to be swallowed or inhaled. It must be said that a swallowed appliance may have to be surgically removed, and inhaled appliances may lead to respiratory arrest and death.
- As with any medical or dental treatment, unusual occurrences can and do happen. These possibilities could include minor tooth movement, broken or loosen teeth of dental restorations, sore mouth, changes in bite or occlusion periodontal problems, muscle spasms, ear pain, neck pain, etc. Any of the mentioned complications are rare, but theoretically may occur. Additional medical and dental risk that have been mentioned may occur.
- You must always bring your splint with you for each appointment. Your splint will be re-evaluated in approximately six weeks form the time you receive it and may require a change in the treatment position at that time.
- Any balance after insurance payments are patient responsibility. Please communicate with the office staff and remit payment when services are rendered. If no payment is received within 60 days, you will be sent to collections and charged a $200 processing fee.

I have read or had read to me the information in this information consent, realized the risk and limitations involved, and consent to treatment. I understand that any of my photographs, models, and x-rays may be used in scientific papers or demonstrations.

I also understand that Dr. Priya Mistry is not a contractual provider with any insurance company.

_____ _____

Signature of Patient and/or Legal Guardian Date

_____

Printed Name of Patient

Authorization to Disclose Health Information

Patient Name: _____ Date: _____
Date of Birth: _____ Phone Number: _____

1. I authorize the use or disclosure of health information described below from the following individual, office or organization:

Priya Mistry, DDS
16415 SE 15th St. Ste# 103
Vancouver, WA 98683

2. The type and amount of information to be used or disclosed is as follows:
   _____Entire health record, or any part
   _____Entire billing record, or any part
   _____Imaging (CT scan)
   _____Other information (Specify):_____

3. This information may be disclosed to and used by:

Name: _____ Association: _____
Address: _____Phone:_____

Name: _____ Association: _____
Address: _____Phone:_____

Name: _____ Association: _____
Address: _____Phone:_____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the individual, office, or organization address listed above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contests claim under my policy.
   Unless otherwise revoked, this authorization will expire on the following date, or condition:

   ☐ In one year

   ☐ Other:_____

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed to the authorized individual(s) above may have potential to be subject to unauthorized re-disclosure, and the information may not be protected by HIPAA law and federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office/ organization of Priya Mistry, DDS , 16415 SE 15th St. Ste# 103 Vancouver, WA 98683, phone: (503)255-8293 or Fax: (503) 252-1214.

   PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from other providers or facilities.

Printed: _____

Signature: _____ Date: _____

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Sleep Apnea Risk Awareness Survey

Patient Name: _____ Date: _____

Have you ever had a sleep study done? YES / NO

If so then when? Date: _____ Results of Test: _____

Do you awaken more than once at night to urinate?	YES	NO
Do you snore?	YES	NO
Has anyone observed you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood pressure?	YES	NO
Is your Body Mass Index (BMI) more than 35?	YES	NO
Do you feel "worse" when you wake up?	YES	NO
Do you often feel tired or sleepy during the day?	YES	NO
Is your neck circumference 16 inches or greater?	YES	NO
Do you suffer from morning headaches?	YES	NO
Do you wake up gasping for air at night?	YES	NO
Is your age over 50 years old?	YES	NO
Has your concentration, memory, or temper (irritability) been worsening?	YES	NO

Other notes:

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Epworth Sleepiness Scale

How likely are you to nod odd or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	**Slight chance of nodding off 1**	**Moderate chance of nodding off 2**	**High chance of nodding off 3**
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				
			TOTAL SCORE	

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why are you sleepy.

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

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

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial Pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Inability to open mouth	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Migraine Headaches	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
	Other - write in:		
____	_____	____	____
____	_____	____	____

Patient Signature

_____

Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other _____ _____
_____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other _____ _____
_____ _____

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

	Practitioner	Specialty	Treatment & approximate date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y☐ N☐ Adenoids Removed
Y☐ N☐ Tonsils Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Bruising easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fibromyalgia
Y☐ N☐ Fluid retention
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Hypoglycemia

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Kidney problems
Y☐ N☐ Liver disease
Y☐ N☐ Meniere's disease
Y☐ N☐ Menstrual cramps
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle aches
Y☐ N☐ Muscle shaking (tremors)
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nervousness
Y☐ N☐ Neuralgia
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Ovarian cysts
Y☐ N☐ Parkinson's disease
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
☐ Frequent Colds
☐ Ear Infections
☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders
Y☐ N☐ Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN LOCATION	SEVERITY			FREQUENCY			DURATION				
	MILD	MODERATE	SEVERE	OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

JAW PAIN

L R B Jaw pain - on opening
L R B Jaw pain - while chewing
L R B Jaw pain - at rest

JAW SYMPTOMS

Y☐ N☐ Jaw clicks
Y☐ N☐ Jaw locks closed
Y☐ N☐ Jaw locks open
Y☐ N☐ Jaw popping
Y☐ N☐ Teeth clenching
Y☐ N☐ Teeth grinding

EYE RELATED CONDITIONS

Y☐ N☐ Blurred vision
Y☐ N☐ Double vision
Y☐ N☐ Eye pain
Y☐ N☐ Pain or pressure behind the eyes
Y☐ N☐ Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

Y☐ N☐ Buzzing in the ears
Y☐ N☐ Ear congestion
Y☐ N☐ Ear pain
Y☐ N☐ Hearing loss
Y☐ N☐ Pain behind the ear
Y☐ N☐ Pain in front of the ear
Y☐ N☐ Recurrent ear infections
Y☐ N☐ Tinnitus (ringing in the ear)

THROAT NECK & BACK RELATED CONDITIONS

Y☐ N☐ Back pain - lower
Y☐ N☐ Back pain - middle
Y☐ N☐ Back pain - upper
Y☐ N☐ Chronic sore throat
Y☐ N☐ Constant feeling of a foreign object in throat
Y☐ N☐ Difficulty in swallowing
Y☐ N☐ Limited movement of neck
Y☐ N☐ Neck pain
Y☐ N☐ Numbness in the hands or fingers

Patient Signature _____ Date _____

THROAT NECK & BACK RELATED CONDITIONS (Continued)

Y☐ N☐ Sciatica
Y☐ N☐ Scoliosis
Y☐ N☐ Shoulder pain
Y☐ N☐ Shoulder stiffness
Y☐ N☐ Swelling in the neck
Y☐ N☐ Swollen glands
Y☐ N☐ Thyroid enlargement
Y☐ N☐ Tightness in throat
Y☐ N☐ Tingling in the hands or fingers
Y☐ N☐ Torticollis

MOUTH & NOSE RELATED CONDITIONS

Y☐ N☐ Broken teeth
Y☐ N☐ Burning tongue
Y☐ N☐ Chronic sinusitis
Y☐ N☐ Dry mouth
Y☐ N☐ Frequent biting of cheek
Y☐ N☐ Frequent snoring

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

_____

What do you believe is the cause of your pain or condition?

Pick one:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related incident ☐ Playground incident
☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Illness ☐ Injury
☐ Unknown ☐ Other _____

If accident, date _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important to your pain or condition? _____

_____

FAMILY HISTORY

Have any members of your family (blood kin) had: Y☐ N☐ Headaches Y☐ N☐ High blood pressure
Y☐ N☐ Heart disease Y☐ N☐ Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y☐ N☐ If yes, how many children? _____ What are their ages? _____

Y☐ N☐ Are you currently under unusual stress?
Y☐ N☐ Recent change in lifestyle?
Y☐ N☐ Do you exercise regularly?

Y☐ N☐ Do you chew tobacco?
Number of caffeine drinks per day _____

Y☐ N☐ Do you smoke?

_____ *Number of* ☐ Packs ☐ Cigarettes *per* ☐ Day ☐ Week

Alcohol consumption

☐ None ☐ Social Drinker
☐ Occasional ☐ Daily

Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

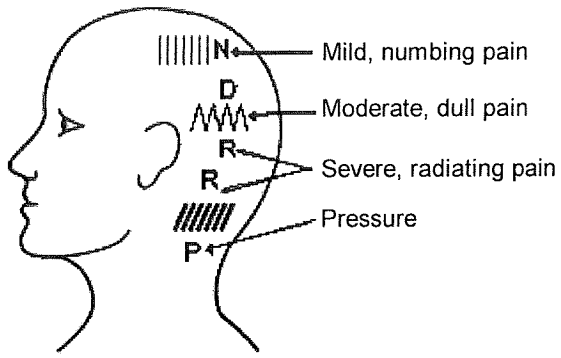
MILD PAIN

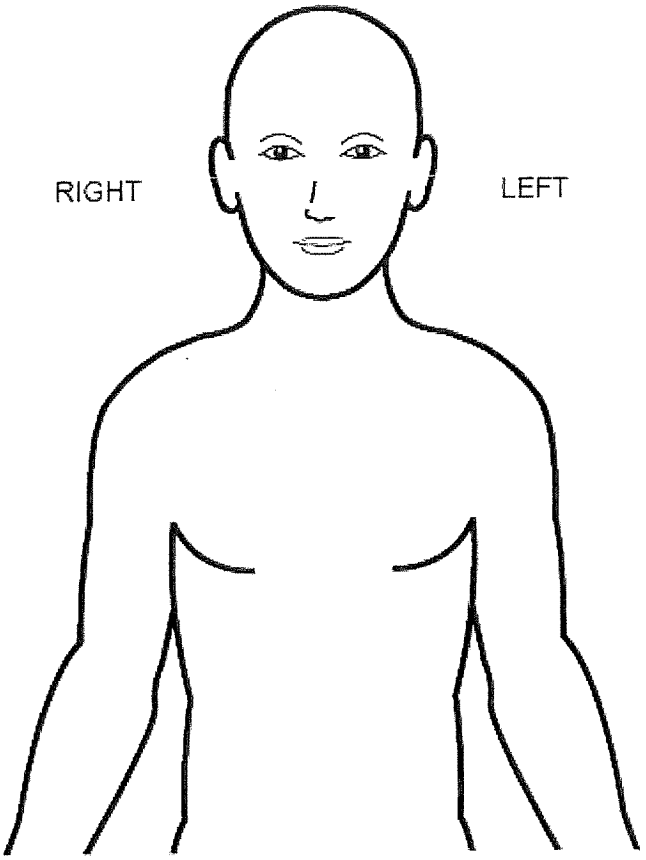
MODERATE PAIN

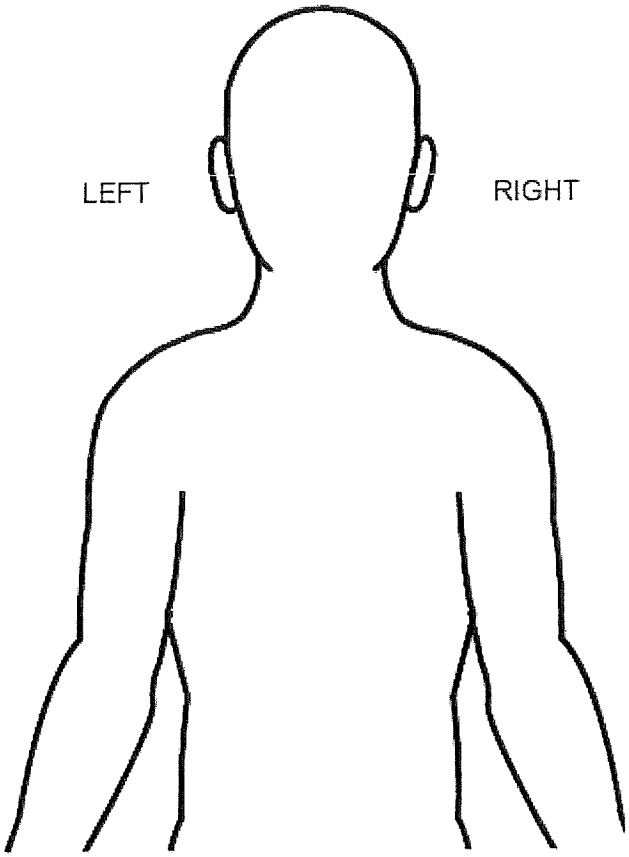
SEVERE PAIN

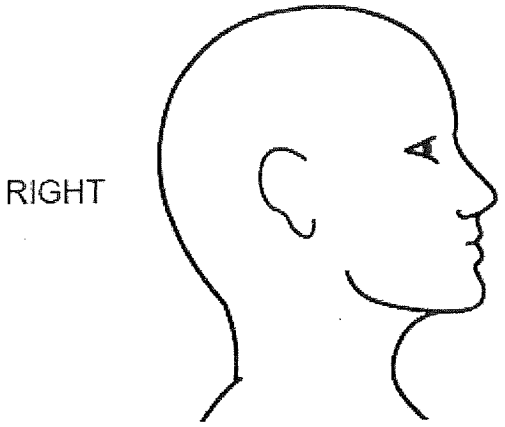
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

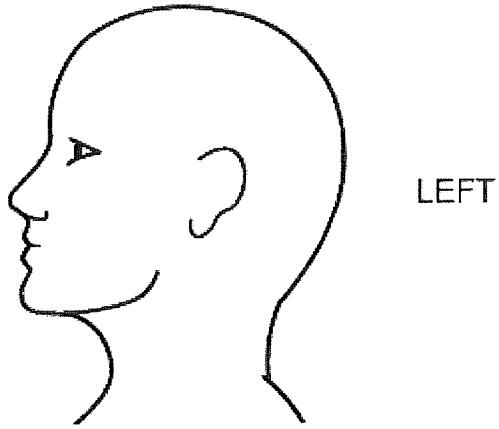
EXAMPLE











Patient Signature _____ Date _____

HISTORY OF ACCIDENT

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

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ? (Choose one)

- ☐ A passenger in a vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work

AND... (Choose one)

- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- ☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- ☐ At front end
- ☐ At rear end
- ☐ At front right area
- ☐ At front left area
- ☐ At rear right area
- ☐ At rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- ☐ Other _____

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
- ☐ Driver's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Interior of car
- ☐ Other _____

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

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back
- ☐ Other: _____

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

_____

DID YOU GO TO THE HOSPITAL? ☐ Yes ☐ No ☐ By Car ☐ By Ambulance

☐ TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU ☐ SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

HAS A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

☐ Yes ☐ No If yes, please explain _____

_____

Patient Signature _____ Date _____

IF YOU HAD A PREVIOUS ACCIDENT, PLEASE GIVE AN ACCURATE DESCRIPTION, _____

_____

_____ INCLUDING DATE: _____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE TREATED FOR THIS PREVIOUS ACCIDENT: _____

_____

_____

IF YOU HAVE MISSED ANY WORK PLEASE GIVE DATES: _____

_____

INSURANCE INFORMATION

AUTO INSURANCE

Please mark each insurance category

☐ your insurance ☐ driver of vehicle's insurance ☐ other vehicle's insurance ☐ owner of vehicle's insurance

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____ Insured's Birth date. _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Claim No. _____ Has this been reported? ☐ Yes ☐ No

OTHER TYPES OF INSURANCE

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

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____ Insured's Birth date. _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No _____

WORKER'S COMPENSATION

Employee _____

Address _____

City, State, Zip _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? ☐ Yes ☐ No If yes, was treatment authorized? _____

Insurance Co. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No _____ Group No. _____ I.D. No. _____

If you have additional insurance, please enter the information on the reverse side of this form.

Patient Signature _____ Date _____

ATTORNEY INFORMATION

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

Attorney's Name _____ Paralegal _____ Phone No. _____

Address _____

City, State, Zip _____

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

I authorize 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 understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Insurance Company _____

☐ Group Health ☐ Auto ☐ Government ☐ Self Insured ☐ Dental

Contact Person _____

Effective date of this policy _____ TMJ policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Is there a policy maximum for TMJ disorders? _____

Is precertification required _____

Can benefits be assigned to doctor? ☐ Yes ☐ No

What information is needed to process the claim? _____

_____

_____

For No Fault: Amount of benefits _____

Mailing Address _____

City, State, Zip _____

Adjuster _____ Assignment approved ☐ Yes ☐ No

By _____

Other: _____

_____

_____

_____

Patient Signature _____ Date _____