TMJ Therapy, Inc.
Carl K. McMillan, DDS, FAACP

PATIENT INFORMATION

INSTRUCTIONS: Please print. Try to answer all the questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostic decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason for each question asked. This information will remain confidential at all times. We realize that it may take considerable time to complete this form. We can assure you that all of this information will be reviewed in detail before, during, and after your examination.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Which of the phone numbers above is the best number to get a hold of you (please circle)?

Age: _____ Birth date: _____ Social Security number: _____

Marital Status (please circle): Child Single Married Divorced Separated Widowed

Employed by: _____ Work phone: _____ Occupation: _____

Name of spouse (if applicable): _____Cell phone: _____

Spouse's birth date: _____ Social Security number: _____

Employed by: _____ Work phone: _____ Occupation: _____

Who is responsible for payment? _____ Relationship to patient: _____

Home phone: _____ Address: _____

Birth date: _____ Social Security number: _____

Employed by: _____ Work phone: _____ Cell phone: _____

Who (not living with you) may we contact in case of an emergency? _____

Relationship to patient: _____ Home phone: _____ Cell phone: _____

Who may we thank for referring you to our office? _____

If this individual is a doctor or therapist, indicate his/her field specialty: _____

Address: _____ Phone: _____

When was your last visit? _____ Are you presently under the care of this person? _____

Patient/responsible party signature: _____ Date: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency services, or any services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

All medical/dental services furnished are charged directly to you and **you are personally responsible for the payment of all services.** This office will help prepare insurance forms or assist in making collections from your insurance companies and will credit any such collections to your account, or reimburse you as necessary. However, this office cannot render services under the assumption that our charges will be paid by an insurance company.

A service charge of 2% a month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for my care can only be extended for a period of up to three months from the date of this initial consultation.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five days of billing, if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof.

I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

I grant my permission to this company to call me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment, and agree to their content.

_____
Printed Name

_____ Date: _____ Relationship to patient: _____
Signature of patient/responsible party

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices by TMJ Therapy, Inc., detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ Date: _____ Relationship to patient: _____
Signature of patient/responsible party

I give my consent to Dr Carl McMillan and/or assistants for the examination/consultation and evaluations needed.

Patient/responsible party signature _____ Date _____

TMD/SLEEP PATIENT QUESTIONNAIRE

What are the chief complaints for which you are seeking treatment?
Please number your complaints, with #1 being the most important.

NOTE: If you are currently symptom-free due to the use of CPAP, please fill this out with the symptoms you experience when you don't use CPAP.

___Frequent heavy snoring
___ Frequent heavy snoring, which affects the sleep of others
__ Significant daytime drowsiness
__ I have been told that "I stop breathing when sleeping"
__ Difficulty falling asleep
__ Gasping when waking up
__ Nighttime choking spells
__ Feeling unrefreshed in the morning
__ Morning hoarseness
__ Morning headaches
__ Swelling in ankles or feet
__ Nocturnal teeth grinding
__ Jaw pain
__ Facial pain
__ Jaw clicking

__ Head pain
__ Neck pain
__ Difficulty speaking
__ Difficulty swallowing
__ Snoring
__ Limited opening/jaw locking
__ Poor sleep
__ Feeling restless when laying down
__ Waking up frequently

If you have headaches, what symptoms do you experience with the headaches?
__Nausea
__ Light sensitivity
__ Noise sensitivity
__ Dizziness
__ Blurred vision
__ Fatigue

Other: _____

Signature of patient/responsible party _____ Date _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Signature of patient/responsible party _____ Date _____

BERLIN SLEEP QUESTIONNAIRE

1. Complete the following:
height _____ age _____
weight _____ male/female (circle)

2. Do you snore?
☐ yes
☐ no
☐ don't know

If you snore:
3. Your snoring is?
☐ slightly louder than breathing
☐ as loud as talking
☐ louder than talking
☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?
☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

5. Has your snoring ever bothered other people?
☐ yes
☐ no

6. Has anyone noticed that you quit breathing during your sleep?
☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

7. How often do you feel tired or fatigued after you sleep?
☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

8. During your waketime, how often do you feel tired, fatigued or not up to par?
☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
☐ yes
☐ no

If yes, how often does it occur?
☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

10. Do you have high blood pressure?
☐ yes
☐ no
☐ don't know

FOR OFFICE USE

Scoring questions: Any answer within the box outline is a positive response
Scoring categories
Category 1 is positive with 2 or more positive responses to questions 2-6 ☐
Category 2 is positive with 2 or more positive responses to questions 7-9 ☐
Category 3 is positive with 1 positive response and/or a BMI> 30 ☐

Final Result : 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Signature of patient/responsible party _____ Date _____

HISTORY OF PRESENT ILLNESS

Have you been medically diagnosed with (check all that apply):

☐ Y ☐ N Migraine Headaches
☐ Y ☐ N Tension Headaches
☐ Y ☐ N Sleep Apnea

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No
If Yes, please provide the following information:

Sleep Center name: _____

Location: _____

Sleep Study Date: _____

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The evaluation is confirmed a diagnosis of: ☐ mild, ☐ moderate, ☐ severe obstructive sleep apnea
The evaluation showed an RDI of _____ and an AHI of _____

CPAP INTOLERANCE

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section:

I could not tolerate the CPAP device due to:
☐ Masks leaks
☐ I was unable to get the mask to fit properly
☐ Discomfort caused by the straps and headgear
☐ Disturbed or interrupted sleep caused by the presence of the device
☐ Noise from the device disturbing my sleep and/or bed partner's sleep
☐ CPAP restricted movements during sleep
☐ CPAP does not seem to be effective
☐ Pressure on the upper lip causing tooth related problems
☐ A latex allergy
☐ Claustrophobic associations
☐ An unconscious need to remove the CPAP apparatus at night
☐ Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you tried for breathing disorders? (weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

Signature of patient/responsible party _____ Date _____

MEDICAL HISTORY

Have any of the following medications 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

Other allergens:

_____
_____
_____
_____

List any medications you are currently taking:

☐ Y ☐ N Antacids
☐ Y ☐ N Antibiotics
☐ Y ☐ N Anticoagulants
☐ Y ☐ N Antidepressants
☐ Y ☐ N Anti-inflammatory drugs (non-steroid)
☐ Y ☐ N Barbiturates
☐ Y ☐ N Blood thinners
☐ Y ☐ N Codeine
☐ Y ☐ N Cortisone
☐ Y ☐ N Diet pills
☐ Y ☐ N Heart medication
☐ Y ☐ N High blood pressure 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 current medications:

_____
_____
_____
_____

Medical History

☐ Y ☐ N Anemia
☐ Y ☐ N Arteriosclerosis
☐ Y ☐ N Asthma
☐ Y ☐ N Autoimmune disorders
☐ Y ☐ N Bleeding easily
☐ Y ☐ N Sinus problems
☐ Y ☐ N Congestive heart failure
☐ Y ☐ N Current pregnancy
☐ Y ☐ N Diabetes
☐ Y ☐ N Dizziness
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fibromyalgia
☐ Y ☐ N Frequent sore throats
☐ Y ☐ N Gastroesophageal Reflux Disease (GERD)
☐ Y ☐ N Hay fever
☐ Y ☐ N Heart disorder
☐ Y ☐ N Heart murmur
☐ Y ☐ N Irregular heart pounding/beating at night
☐ Y ☐ N Heart pacemaker
☐ Y ☐ N Heart valve replacement
☐ Y ☐ N Heartburn or a sour taste in the mouth at night
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure
☐ Y ☐ N Immune system disorder
☐ Y ☐ N Injury to face, neck, head, mouth, teeth (circle)
☐ Y ☐ N Insomnia
☐ Y ☐ N Jaw joint surgery
☐ Y ☐ N Low blood pressure
☐ Y ☐ N Memory loss
☐ Y ☐ N Migraines
☐ Y ☐ N Morning dry mouth
☐ Y ☐ N Muscle spasm or cramping
☐ Y ☐ N Using extra pillows to help breathing at night
☐ Y ☐ N Nighttime sweating
☐ Y ☐ N Osteoarthritis
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Poor circulation
☐ Y ☐ N Prior orthodontic treatment
☐ Y ☐ N Recent excessive weight gain
☐ Y ☐ N Rheumatic fever
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Swollen, stiff or painful joints
☐ Y ☐ N Thyroid problems
☐ Y ☐ N Tonsillectomy (have had)
☐ Y ☐ N Wisdom teeth extraction

Other medical history:

_____
_____
_____
_____

Signature of patient/responsible party _____ Date _____

INSURANCE INFORMATION

Please provide us with your insurance cards so that we can make copies.

Primary Medical Insurance: _____ Subscriber ID: _____

Subscriber: _____ Date of birth: _____

Social Security Number: _____ Relationship to patient: _____

Insurance phone: _____ Insurance address: _____

Secondary Medical Insurance: _____ Subscriber ID: _____

Subscriber: _____ Date of birth: _____

Social Security Number: _____ Relationship to patient: _____

Insurance phone: _____ Insurance address: _____

I certify that I, and/or my dependant(s), have insurance coverage with the insurance company(ies) named above and assign directly to TMJ Therapy, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance company. I authorize the use of my signature on all insurance submissions.

TMJ Therapy, Inc. may use my health care information and may disclose such information to the here-to-for named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is complete, or two years form the date signed below.

_____ _____ _____

Signature of patient/responsible party Date Relationship to patient

FAMILY HISTORY

1. Have had members of your family (blood kin) had:
   - ☐ Y ☐ N Heart disease
   - ☐ Y ☐ N High blood pressure
   - ☐ Y ☐ N Diabetes
2. Have any immediate family members been diagnosed or treated for a sleep disorder? ☐ Y ☐ N

SOCIAL HISTORY

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Do you smoke: ☐ Y ☐ N Do you use chewing tobacco? ☐ Y ☐ N

I authorize the release of a full report of examination findings, diagnosis, treatment programs, 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.

Signature of patient/responsible party _____ Date - _____