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: _____

Email: _____

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

Age: _____ Birth date: _____

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

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 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: _____

City: _____ Phone: _____

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

Patient/responsible party signature: _____ Date: _____

Financial Policy

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. X-RAY** costs are not included in consultation fee. 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.

_____ 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. A copy may be obtained at any time.

_____ Date: _____ Relationship to patient: _____

Signature of patient/responsible party

Consent for Exam

I_____ give my consent to Dr. Carl McMillan and/or assistants for the examinations/consultations and evaluations of my TMJ. I give my consent for TMJ Therapy, Inc. to download and review my prescription history.

Patient/responsible party signature: _____ Date: _____

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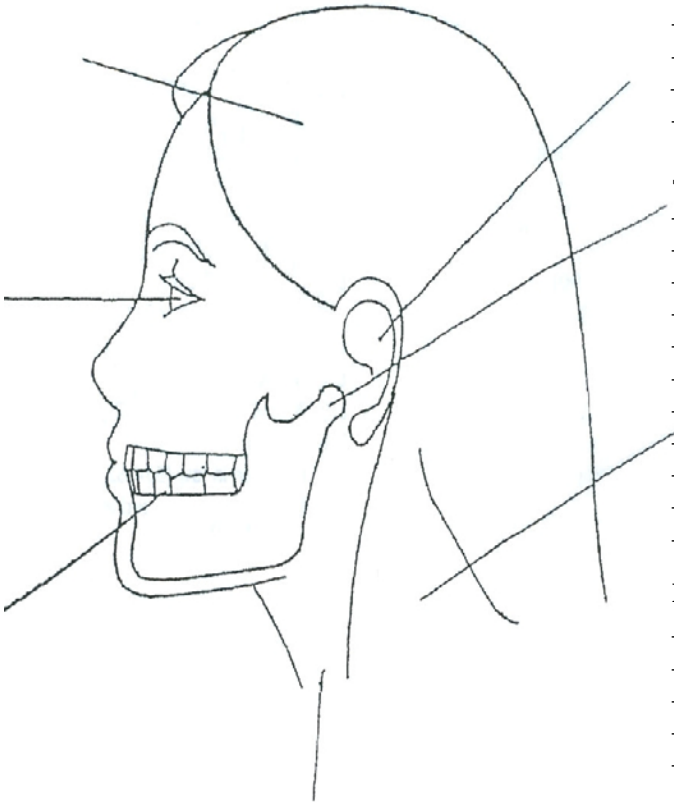
Symptom Map

You may have a temporomandibular joint (TMJ) condition, indicated by the list of symptoms below.
Please **mark an X** next to the symptoms you are experiencing.

Headache/Head Pain:
___Forehead
___Temple
___Back of head
___Hair/scalp
___Tender to touch
___Sinus-type
___Migraine-type

Eyes:
___Pain in/behind eyes
___Bloodshot eyes
___Blurred vision
___Visual disturbances

Mouth/Throat:
___Teeth clenching
___Grinding teeth _
___Tooth pain
___Loose teeth
___Teeth misaligned
___Throat pain
___Difficulty swallowing
___Frequent coughing
___Frequent throat clearing



Ears:
___Ear pain (no infection)
___Ear congestion
___Ringing/buzzing/hissing
___Reduced hearing
___Dizziness

Jaw/Face:
___Jaw pain
___Jaw locking/catching
___Clicking jaw/ jaw popping
___Jaw joint noises
___Limited mouth opening
___Inability to open smoothly
___Pain when chewing
___Jaw deviates to the side
___Facial pain
___Muscle spasm/cramps
___Sinus congestion

Neck/Shoulders:
___Neck pain
___Shoulder pain
___Back pain
___Arm/finger pain
___Arm/finger numbness

Please use this space below to indicate anything else about yourself which you believe may be related to your pain or condition: _____

_____

I, the undersigned (patient or legally responsible party), authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating physician. I additionally authorize the release of any medical information to my insurance companies or for legal documentation to process claims.

I assume financial responsibility for services rendered. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

It is understood that all X-rays, records, models and photographs taken remain the property of TMJ Therapy, Inc. Copies of these records may be obtained for an additional fee.

Signature _____ Date _____

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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	☐ Motorcycle accident	☐ Work related incident	☐ Illness
☐ Athletic endeavor	☐ Fight	☐ Accident	☐ Injury
☐ Unknown	☐ Fall	☐ Playground incident	
☐ 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 kind) had:

Y	N	Headaches/Migraines	Y	N	High blood pressure
Y	N	Heart disease	Y	N	Diabetes
Y	N	Depression/Anxiety			

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 smoke

Y N Do you chew tobacco?

Y N Do you use caffeine?
Number of caffeine drinks per day_____

Alcohol consumption

___None ___Social Drinker

___Occasional ___ Daily

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

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

Other_____
_____
_____

In the last 2 weeks have you taken an anti-inflammatory/pain medication for your condition?
Y N
Has the pain persisted after using these medications? Y N

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.			

I give permission to TMJ Therapy to view/download my medication history from SureScripts to prevent any drug interactions.

Patient Signature _____ Date _____

MEDICAL HISTORY

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 High Blood pressure
Y N Low blood pressure
Y N Bruising easily
Y N Cancer
Y N Tumor
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 Fluid retention
Y N Frequent illnesses
Y N Prior orthodontic treatment

Y N Dental implants
Year:_____ How many:_____

Y N Fibromyalgia
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 valve replacement
Y N Hemophilia
Y N Hepatitis
Y N Hypoglycemia
Y N Immune system disorder
Y N Injury to Head/Neck/Mouth/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 cramps/spasms
Y N Muscular dystrophy
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 Psychiatric care
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/painful joints
Y N Tired muscles
Y N Tuberculosis
Y N Urinary disorders
Y N Wisdom teeth extraction

Other: _____
_____

Patient Signature_____ Date _____

INSURANCE INFORMATION

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

Primary Medical Insurance: _____ Subscriber: _____

DOB of subscriber**:** _____ Subscriber ID: _____

Subscriber's relationship to patient: _____Insurance phone: _____

Insurance address: _____City _____State____ Zip code_____

Secondary Medical Insurance: _____ Subscriber: _____

DOB of subscriber**:** _____ Subscriber ID: _____

Subscriber's relationship to patient: _____ Insurance phone: _____

Insurance address: _____City _____State____ Zip code_____

Primary Dental Insurance: _____ Subscriber: _____

Group Name or #**:** _____ Subscriber ID: _____

DOB of subscriber: _____ SSN of subscriber: _____

Subscriber's relationship to patient: _____Insurance phone: _____

Insurance address: _____City _____State____ Zip code_____

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

Chief Complaints for Which Patient is Seeking Treatment?

Please number the Complaints starting with #1 being the most severe.

Rate the Complaints for frequency…1-Seldom 2-Occasional 3-Frequent 4-EveryDay

Intensity: 0- No Pain and 10 most Severe

Number		Frequency 1-4	Intensity 0-10
___	Back Pain	_____	_____
___	Dizziness	_____	_____
___	Ear Congestion	_____	_____
___	Ear Pain	_____	_____
___	Eye Pain	_____	_____
___	Facial Pain	_____	_____
___	Fatigue	_____	_____
___	Headaches	_____	_____
___	Inability to Open Mouth	_____	_____
___	Jaw Clicking	_ _____	_____
___	Jaw Joint Noise	_____	_____
___	Jaw Locking	_____	_____

Number		Frequency 1-4	Intensity 0-10
___	Jaw Pain	_____	_____
___	Migraine Headaches	____	_____
___	Muscle Twitching	_____	_____
___	Neck Pain	_____	_____
___	Pain when Chewing	_____	_____
___	Ringing In Ears	_____	_____
___	Shoulder Pain	_____	_____
___	Sinus Congestion	_____	_____
___	Throat Pain	_____	_____
___	Visual Disturbance	_____	_____

Other

_____

_____

Severety:

___Aching ___Acute ___Clusters ___Continual ___Dull ___Episodic ___Fluctuating

___Incapacitating ___ Mild ___ Moving ___Pressure ___ Progressive ___Ringing

___Roaring ___Rotational ___Severe ___Sharp ___Spinning

Diagnosis/Assessment

* Left- Right-Both

Joint Sounds

L R B Early Opening Click
L R B Middle Opening Click
L R B Late Opening Click
L R B Early closing click
L R B Middle Closing click
L R B Late Closing Click

Dental Relationship

Left
Class:_____
DIV: _____

Right
Class _____
DIV: _____

____ Abnormal Jaw Closure
L R B Anterior disc displacement with reduction (M26.63)
L R B Anterior disc displacement without reduction (S03.0XXA)
L R B Articular Cartilage Disorder (M26.63)
L R B Atypical Facial Pain (G50.1)
L R B Capsulitis of the Temporomandibular joint (M77.9)
L R B Cephalgia (R51)
L R B Cervicalgia (M54.2)
L R B Closed lock of the TMJ (S03.0XXA) ____ Lock is intermittent
L R B Condylar hyperplasia (acquired) (M26.03)
L R B Condylar hypoplasia (acquired) (M27.8)
L R B Crepitus of the TMJ (M26.63)
L R B Degenerative Arthritis (M19.90)
L R B Dislocation of the Jaw,closed (S03.0XXA)
L R B Dislocation of the Jaw Open (S03.0XXS)
_____ Dizziness (R42)
L R B Dysfunction of the Eustachian tube (H69.80)
L R B Earache from referred pain (H92.09)
L R B Episodic tension headache (G44.209)
_____ Exam of individual involved in a MV Traffic accident (Z04.3)
L R B Greater occipital neuralgia (M54.10)
L R B Headache/facial Pain (R51)
---- Late Effects of MV accident (V87.0XXS)
_____ Late effects of other accidents (Y33.XXXS)
_____ Limited mandibular range of motion (M26.52)
L R B Muscle Spasm (M62.838)
L R B Myalgia (M79.1)
L R B Omohyoid muscle syndrome (M62.40)
_____ MV traffic accident involving collision with MV (driver) (V49.88XA)
_____ MV traffic accident involving collision with MV (passenger) (V49.S9XA)
L R B Jaw Pain (R68.84)
L R B Pain in/around eye (H57.10)
L R B Temporal Tendinitis (M77.9)
L R B Tension Headaches (G44.209)
L R B Tinnitus (H93.19)
L R B Trauma to the head and neck (S19.80XA)
_____ Trigeminal neuralgia (G50.0)
_____ Whiplash (S13.4XXA)

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Muscle Palpations:

Left	Right		Left	Right	
0123	0123	Anterior temporalis	0123	0123	Greater occipital
0123	0123	Middle Temporalis	0123	0123	Lesser occipital
0123	0123	Posterior temporalis	0123	0123	Splenius capitus
0123	0123	Lateral TMJ capsule	0123	0123	Trapezius neck area
0123	0123	Posterior joint space	0123	0123	Trapezius Shoulder area
0123	0123	Deep Masseter	0123	0123	Cervical vertebra
0123	0123	Superficial masseter	0123	0123	Temporal tendon
0123	0123	Stylomandibular ligament	0123	0123	Medial pterygoid
0123	0123	Anterior digastric	0123	0123	Intra-articular region
0123	0123	Posterior digastric	0123	0123	Pre-articular region
0123	0123	Sternocleidomastoid	0123	0123	Lateral collateral ligament
0123	0123	Styloid process	0123	0123	Parotid gland
0123	0123	Occipital	0123	0123	Mylohyoid

Prognisis:

_____Excellent _____Good _____ Fair _____ Guarded _____Poor _____Unknown

___There **may** be permanent impairment
___There will most likely be **no** permanent impairment
___In my opinion to a reasonable degree of medical certainty this condition **was** caused by the **accident** that occurred on: **Date: _____ City:_____ State:_____**

NEUROMUSCULAR PATIENT **Y N**

# OF ORTHOTICS	DIAGNOSTICS	VISITS/ADJUSTMENTS	MASSAGES
GELB	FULL WORKUP	4	1
UPPER MORA	TOMOS/TRANSCRANIAL	6	4
LOWER MORA	CEPH	8	6
HAWLEY HEADACHE	PANO	12	8
ERKOLOC/ESSEX	EMG		
TAP 3	JVA/JT		
LONG-TERM ERK.	PHOTOS/SM'S		