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WELCOME TO TMJ THERAPY

Patient Information:

Name: ______________________________

Address: ______________ City: ______________ State: _____ Zip: ______________

Phone #: ______________ Email: ______________

Birth date: ______________ Age: _________ Gender: Male Female Other: ______________

Ethnicity/Race: ______________ Primary Language: ______________

Marital Status: Single Married Divorced Separated Widowed

Employed by: ______________ Occupation: ______________

Emergency contact name: ______________ Relationship to patient: _______ Phone #: ______________

Responsible Person:

Name of person responsible for the Insurance Policy? ______________ Birth date: ______________

Employed by: ______________ Social Security #: ______________

Relationship of the patient to the subscriber (please circle): Self Spouse Other ______________

Subscribers Phone #: ______________ Subscribers Address: ______________

Name of Primary Medical Insurance**:** ______________ Subscriber ID**:** ______________

Insurance Phone #: ______________ Insurance Address: City: ______________ State: _____

Name of Secondary Medical Insurance: ______________ Subscriber ID: ______________

Employed by: ______________ Social Security #: ______________

Relationship to patient (please circle): Self Child Spouse Other ______________

Subscribers Phone #: ______________ Subscribers Address: ______________

Who may we thank for referring you to our office? Name: ______________ City: ______________

Their Field of Specialty: (ie: dentist, doctor) ______________

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company(ies) named above and assigned 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 from the date signed below.

______________________________ ______________ ______________________

Signature of patient/responsible party Date Relationship to patient

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. First X-Ray cost is included in the $489.00 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 30 business day after treatment is final. 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% 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.

________________________________ __________________ __________________________

Signature of patient/responsible party   Date   Relationship to Patient

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.

________________________________ _____________________ _________________________

Signature of patient/responsible party   Date   Relationship to Patient

CONSENT FOR EXAM

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

____________________________________ ____________________ ________________________

Signature of patient/responsible party   Date   Relationship to Patient

Release of Medical Records

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

Patient Name: ____ Date: ____________________________________

You may have a temporomandibular joint (TMJ) condition, indicated by the list of symptoms below.

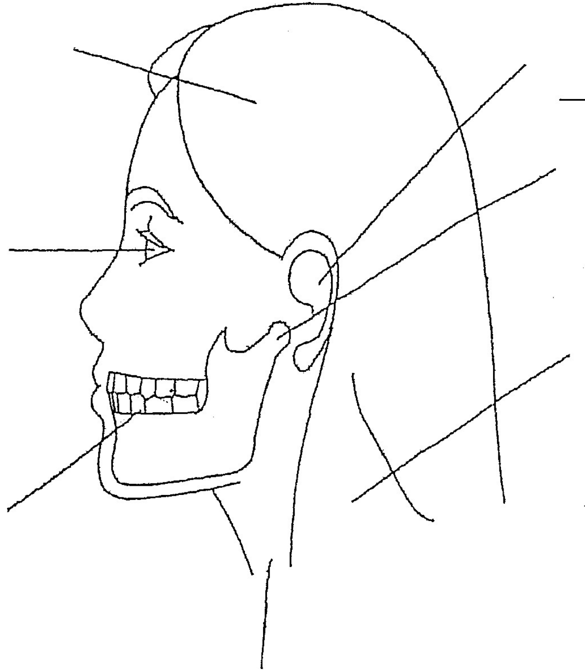
Please Mark an X next to the symptoms you are experiencing and then number the top 4 symptoms!

(Example: _X_ Forehead #1 _X_ Jaw Pain #2 _X_ Neck Pain #3 _X_ Loose teeth #4)

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

How would you describe your most severe symptom on a scale of 1-10? Choose all that apply

___ Aching ___ Acute ___ Clusters ___ Continual ___ Dull ___ Episodic ___ Fluctuating ___ Incapacitating

___ Mild ___ Moving ___ Pressure ___ Progressive ___ Ringing ___ Roaring ___ Rotational ___ Severe

___ Sharp ___ Spinning

HISTORY OF SYMPTOMS:

When did you first notice this condition? Month/Year: ____

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 ______________ **Place of accident: City** ______________________ **State** _______________

Taken to Hospital? Y N **By Ambulance? Y N** **When released?** ____________________________

Please list any treatments you have had for TMJ Disorder? ____

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? __________________________________

Health History

This questionnaire was designed to provide important facts regarding the history of your pain or condition. To assist in reaching a diagnosis and determining the source of your problem, please take your time and answer each question as completely and honestly as possible.

My Average Weight: _____________ **Height** ____________

List any allergies you may have:

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

List all medications you are currently taking and the reason why? (Example: Wellbutrin for Depression)

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

Any Hospitalizations or Surgery's in the last 5 years?

________________________ ________________________ ________________________ ________________________

Have you had or are you currently experiencing any of the following?

Y N Jaw Joint Surgery
Y N Anxiety
Y N Tonsils removed
Y N Depression
Y N Sinus problems
Y N Speech difficulties
Y N Chronic Fatigue
Y N Muscle cramps/spasms
Y N Adenoids removed
Y N Wake up unrefreshed
Y N Difficulty concentrating
Y N Frequent snoring
Y N Tooth clenching or grinding
Y N Needing extra pillows to help you breathe at night?
Y N Dizziness
Y N Osteoarthritis
Y N Pregnancy
Y N Parkinson's disease
Y N Sleep Apnea

Have you had an Injury to?

Y N Face Y N Head Y N Neck Y N Mouth Y N Teeth When? ______________ Where? ____________

Primary Care Physician: ________________________ City _____________ State ______

Primary Dentist: ________________________________ City __________________ State __________

Have you had Orthodontics (Braces) on your teeth? Y N Year finished? ______________

Have you had wisdom or other teeth extracted within the last 5 years? Y N What? ______________________

FAMILY HISTORY

Have any members of your family (blood kind) had:

Y N Headaches/Migraines
Y N Depression/Anxiety
Y N Heart Disease
Y N High Blood Pressure
Y N Diabetes

SOCIAL HISTORY

Occupation: _____________________________ # of hours/week work? ________ Where do you work? ________________

Do you have children? Y N If yes, how many? ______ Ages? _______________

Are you caring for parents/grandparents/disabled person/grandchildren? Y N
Any recent change in lifestyle? Y N
What? ________________
Are you currently under any unusual stress? Y N
Do you exercise regularly? Y N

Do you smoke? Y N
Do you chew tobacco? Y N
Do you use caffeine? Y N
Amount of caffeine drinks per day in **oz/cups/mg**?
Tea/Coffee _____ Soda ______ Energy Dinks/Pills________
Alcohol Consumption?
___ None ____ Occasional ___Social Drinker __ Daily ____