CRANIOFACIAL PAIN & JOINT REHABILITATION
TMJ THERAPY INC.

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WELCOME TO TMJ THERAPY

Patient Information:

Name: _____ Email _____

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

Home Phone #: _____ Cell Phone #: _____

Birth date: _____ Age: _____ Gender: ☐Male ☐Female ☐Other: _____

Ethnicity/Race: _____ Primary Language: _____

Social Security #: _____ Marital Status: Single Married Divorced Separated Widowed

Employed by: _____ Occupation: _____

Emergency contact name: _____ Relationship to patient: _____ Phone #: _____

Responsible Person for payment on account: Self / Spouse / Other _____
Primary Medical Insurance**:** _____ Member ID**:** _____

Insurance Phone #: _____ Insurance Address: _____

Primary Subscribers name on Insurance Policy? _____ Birth date: _____

Employed by: _____ Social Security #: _____

Subscribers Phone #: _____ Subscribers Address: _____

Patients relationship to the Insurance Primary Subscriber: Self / Spouse / Child / Other _____

Secondary Medical Insurance: _____ Member ID: _____

Subscribers Name/Address: _____ Date of Birth: _____

Subscribers Phone #: _____ Employer: _____

Patient relationship to the Insurance Subscriber: Self / Spouse / Child / Other _____

Who may we thank for referring you to our office? Name: _____ City: _____
(Please circle one) Google, Facebook, Our website, Instagram, Doctor's office, Dentist office, Friend or Coupon

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 ALL payments. First X-Ray $425.00 and Consultation $149.00.** 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 days 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.

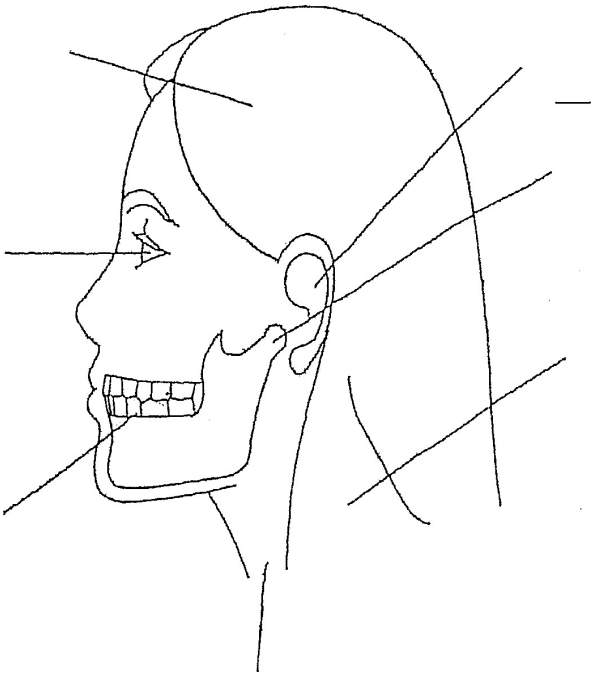
_____ _____

Signature Date

Patient Name: _____ Date: _____

You may have a temporomandibular joint (TMJ) condition, please mark all the symptoms you are having below.

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
- ☐ Light Sensitivity

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
- ☐ Pain in face area
- ☐ Muscle spasm/cramps
- ☐ Sinus congestion

Neck/Shoulders:
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Arm/finger pain
- ☐ Arm/finger numbness

Please rank your TOP 4 complaints from symptoms above?

1. _____
2. _____
3. _____
4. _____

Place the coordinating number from the top four complaints and put in front of the pain word(s) below that describes it best. (you can put multiple #'s on each word):

____Aching ____Acute ____Clusters _____Continual ____Distressing ____Dull ____Episodic
____Excruciating ____Fluctuating ____Hissing ____Incapacitating ____Intense ____Intolerable ____Mild
____Moving ____Numbing ____Pressure ____Progressive ____Ringing ____Roaring ____Rotational
____Severe ____Sharp ____Shocking/electrical _____Spinning ____Tight ____Tingling ____Unbearable

What is the main reason you are seeking treatment at TMJ Therapy?

_____

Have any of these conditions limited your ability to work and/or earn a living? ☐ Yes ☐ No

HISTORY OF SYMPTOMS:

When did you first notice these symptoms/condition? _____ Month/Year

How often do they occur? ___Constantly _____times/day _____times/week _____times/month

When do these symptoms typically occur? ___While asleep ___Immediately upon waking ___Morning ___Throughout the day ___Mid-day ___Evening ___Bedtime ___Constantly

What do you believe is the **cause** of your pain or condition? Please mark in front of item:
___ Motor vehicle ___ Motorcycle accident ___ Work related incident ___ Illness ___ Athletic/Sport endeavor

___ Fight ___ Accident ___ Injury ___ Unknown ___Fall ___ Playground incident ___Other/list: _____

ACCIDENT? ___Yes ___ No
What happened? Please describe the event in detail._____

_____

_____

Date of Accident: _____ Place of Accident: _____City _____State
Did you go to the Hospital? ___Yes ___No Which Hospital _____

By Ambulance? ___Yes ___ No Date released from hospital? _____

Legal? ___Yes ____ No Attorney's name representing you: _____

Phone #: _____Address:_____
Paralegal's Name: _____ Law Firms Name: _____

AUTO ACCIDENT? ___Yes ___No Case #: _____Ins Company: _____

WORKERS COMP? __Yes ___No

Representative Information: _____

STRESS level on a scale of 1-10? 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 / 10++ Reason why? _____

TREATMENTS:

Prior treatments for these conditions? ___None ___OTC oral device ___Self-massage ___Ice pack/hot packs ___Doctor/therapist ___Surgical ___Arthrocentesis ___Open reduction ___Nasal or sinus surgery ___Orthognathic surgery ___Uvulu-palatopharyngeoplasty (UP3 or UPPP)

When did this/these procedures occur? _____month/year

Doctor's name, profession and contact info: _____

Which of the following Therapeutic therapies have you tried?

___Medications ___Nightguard ___Splints ___Orthotics ___Retainers ___Braces ___Physical therapy ___Massage therapy ___Chiropractic ___Nutritional therapy ___Mental health counseling

Have you had direct trauma/INJURY to your ___Face ___Head ___Neck ___Mouth ___Teeth ___None?

Date: _____ What happen: _____

What makes your pain/discomfort WORSE?

___Talking ___Chewing ___Stress ___Bright lights ___Any/Head movement ___Other/list _____

What gives you temporary RELIEF **from your pain/discomfort**?

___OTC pain meds ___Ice/heat ___Sleep ___Holding still ___Dark/low lights ___Other/list: _____

HEALTH HISTORY:

To know how your problems came to be and for us to address the root cause of your problems, we need to know as much about your medical history as possible. Please be thorough so we can best target your concerns and recommend the best treatment for you.

My Average Weight: _____ Height _____

Have you had Orthodontics (**Braces**) done on your teeth? ___Yes ___No Year finished? _____
Have you had any teeth **extracted** within the last 5 years? ___Yes ___No How many? _____

Any **Hospitalizations/Surgeries** in the last 5 years? ___Yes ___No (If yes, please list.)

_____ _____ _____

ALLERGIES AND MEDICATIONS:

Do you have Allergies to any Medicine or Medical supplies? ___Yes ___No (If yes please circle all that apply.)

Local Anesthetics, (i.e. lidocaine), Antibiotics, Acetaminophen, Aspirin, Barbiturates, Codeine, Iodine, Ibuprofen, Latex, , Metal, Penicillin, Plastic, Sedatives, Sleeping pills, Sulfa Drugs or sulfa-based drugs, Cholesterol pills, other/list: _____

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

_____ _____ _____
_____ _____ _____

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

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

Primary Care Physician: _____ City _____ State _____

Primary Dentist: _____ City _____ State _____

All doctors and therapist currently treating you: _____

SOCIAL HISTORY

Employed/Homemaker/Unemployed/Retired/Student part time/ Student full time. _____# of hours/week
Employer: _____ Occupation/School: _____

Circle **one** that applies: Single / Married / Widowed for _____ / Separated for _____ / Divorced for _____

Do you have **children**? ___Yes ___No If yes, how many? _____ Age Range _____
Are you caring for Children/Disabled person/Parents/Grandparents/Grandchildren? (Circle all that apply.)

Any **recent change** in lifestyle? ___Yes ___No What? _____

Do you **exercise** regularly? ___Yes ___No ___Occasionally

Do you **smoke**? ___Yes ___No ___Cigarettes ___Vaping ___Medical Marijuana
For how long: _____years Average amount per day: _____

Do you **chew tobacco**? ___Yes ___No
For how long _____years Average amount per day: _____

Do you drink **Alcohol**? ___None ___Daily ___With meals ___Occasional ___Social Drinker
What time of day do you usually drink? ___Morning ___Afternoon ___Evening

Do you use **caffeine**? ___Yes ___No ___Soda/Coffee/Tea ___Pill form/energy drink
How often: ___Daily ___Occasionally ___Monthly
Average amount use? _____
Why do you use it? _____

FAMILY HISTORY (family that is genetically/blood related)

Y N Anxiety	Y N Neurodegenerative Diseases	Y N Lung Disease
Y N Depression	Y N Sleep apnea/Snoring	Y N Cancer
Y N High blood Pressure	Y N Neuralgias/Neuropathy	Y N Diabetes
Y N Headaches/migraines	Y N Heart Disease	Y N long face appearance
Y N Blood disorders	Y N Bone disorders	

Y N Chronic infections (HIV, Hepatitis, recurring pneumonia, etc.)