



WELCOME TO OUR OFFICE

Patient Information

Date: _____ Home Phone() _____ Cell Phone() _____

Patient Name: _____
First Name Middle Initial Last Name

Address: _____ E-mail _____

City: _____ State: _____ Zip: _____ Sex: M F

Age: _____ Date of Birth: ____/____/____ Married Single Minor

Patient's School/Employer _____ Occupation: _____

School/ Employer Address: _____

Family Dentist: _____ Family Physician: _____

Other Healthcare Providers: _____

In case of emergency who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

Person(s) Responsible for Account

Person responsible for account: _____
First Name Middle Initial Last Name

Relationship to patient Self Spouse Parent Other _____ Birthdate: _____

Address (if different from above) _____

City _____ State: _____ Zip: _____ Social Security# _____

Employer _____ Occupation: _____ Business Phone _____

Primary Dental Insurance

Orthodontic Coverage Yes No

Insurance Company _____ Employer _____

Name of subscriber (if different from above) _____

Relationship to patient Self Spouse Child Other _____ Birth date: _____

Address (if different from above) _____

City _____ State: _____ Zip: _____ Social Security# _____

Group# _____ ID# _____

Secondary Insurance (If you have dual insurance)

Orthodontic Coverage Yes No

Insurance Company _____ Employer _____

Name of subscriber (if different from above) _____

Relationship to patient Self Spouse Child Other _____ Birth date: _____

Address (if different from above) _____

City _____ State: _____ Zip: _____ Social Security# _____

Group# _____ ID# _____

Please tell us why you are seeking an evaluation and possible treatment:

Crowding _____ Overbite _____ Don't Like My Smile _____ Appearance _____
 Better Function _____ Airway Assessment _____ Teasing at School _____
 My dentist found the problem _____ I / We don't see a problem _____
 Any Habit(s) Yes No If yes, please check which one (s):
 Thumb sucking Tongue habit Mouth Breathing Any other reason? _____

Medical History

General Health: Good Fair Poor _____
 Under Treatment Yes No Specify _____
 Drugs or Medication Yes No Specify _____
 Allergy to Latex Yes No

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Congenital Heart Defects	<input type="checkbox"/> Fainting
<input type="checkbox"/> Heart Attack or Stroke	<input type="checkbox"/> History of Substance Abuse	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fever or Sun Blisters
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hypertension (High BP)	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Swollen, Stiff, Painful Joints
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Surgery /Pacemaker	<input type="checkbox"/> Hypotension (Low BP)	<input type="checkbox"/> Numbness of Arms/Hands	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bruises Easily	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Hearing Disorders	<input type="checkbox"/> Intestinal Disorders	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Head or Face Injury
<input type="checkbox"/> High/Low Blood Sugar	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Problems

Have the tonsils or adenoids been removed? Yes No What Age? _____
 Does the patient have a tendency for colds? Yes No
 Sore throats? Yes No Ear infections? Yes No
 Has the patient ever had tubes in their ears? Yes No What Age? _____

Dental History

Has the patient ever sucked their thumb or finger? Yes No Until what age? _____
 Does the patient have any speech problems? Yes No
 Does the patient breathe through the mouth? Day Night No
 Has either parent had previous ortho treatment? Yes No
 Does the patient play any musical (mouth) instruments? Yes No
 Have you consulted an orthodontist or another dentist regarding the orthodontic or TMJ problem? Yes No

Authorization

I certify that I and/or my dependant(s), have insurance coverage with _____ and assign directly to Allen J. Sanders DDS, 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 by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information, to the above-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.

In consideration for the professional services rendered to me, or at my request, by Dr. Sanders, I agree to pay therefore the reasonable value of said services to constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone me at home, at my work or on my cellular phone 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 / Guardian _____ Date _____ Relationship to Patient _____

TMJ HEALTH QUESTIONNAIRE

Date _____

CHIEF CONCERN _____
DATE OF ONSET _____

PAIN SYMPTOMS

Do you get headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N	Do you get headaches in the front or back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N	Do you clench your teeth during the day?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Do you clench your teeth at night?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N			
Are your teeth sore when you awaken?	Y	N	When are your pain symptoms the worst?		

Have your wisdom teeth been extracted? Y N Does anything make you feel better? _____

What medications, if any, are you taking? _____ How often do you take medication for relief of pain? _____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries?	Y	N	Details _____		

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint?	Y	N
Are there any foods you avoid eating?	Y	N	Has your jaw ever locked when you were unable to open or close?	Y	N
Do you ever get dizzy?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you ever feel faint?	Y	N	Have you ever had pain in either jaw joint?	Y	N
Do you ever feel nauseated?	Y	N	Does your jaw ache when you open wide?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N			

EAR AND EYE SYMPTOMS

Do you have pain in either ear?	Y	N	Do you wear glasses or contacts?	Y	N
Do you suffer from any loss of hearing?	Y	N	Are there times when your eyesight blurs?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N	Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N
Do you snore at night?	Y	N	Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N