TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY _____

PHYSICIAN NAME & ADDRESS _____

_____ REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
___	Back Pain	___	___
___	Dizziness	___	___
___	Ear Congestion	___	___
___	Ear Pain	___	___
___	Eye Pain	___	___
___	Facial Pain	___	___
___	Fatigue	___	___
___	Headaches	___	___
___	Jaw Clicking	___	___
___	Jaw Joint Noises	___	___
___	Jaw Locking	___	___
___	Jaw Pain	___	___
___	Limited Mouth Opening	___	___
___	Muscle Soreness	___	___
___	Muscle Twitching	___	___
___	Neck Pain	___	___
___	Pain when Chewing	___	___
___	Ringing in the Ears	___	___
___	Shoulder Pain	___	___
___	Sinus Congestion	___	___
___	Throat Pain	___	___
___	Visual Disturbances	___	___
Other - write in:	___	___	___

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
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:
_____
_____
_____
_____

Patient Signature _____ Date _____

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LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other current medications: _____

MEDICAL HISTORY

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent snoring
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☐ Immune system disorder
Y☐ N☐ Injury to ☐Face ☐Neck ☐Teeth ☐Head ☐Mouth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Meniere's disease
Y☐ N☐ Migraines
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Sleep Apnea
Y☐ N☐ Speech difficulties
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Teeth clenching or grinding
Y☐ N☐ Wisdom teeth extraction

Other medical history:
_____
_____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY: MILD	SEVERITY: MODERATE	SEVERITY: SEVERE	FREQUENCY: OCCASIONAL (MONTHLY OR LESS)	FREQUENCY: FREQUENT (WEEKLY)	FREQUENCY: CONSTANT (EVERY DAY)	DURATION: SECONDS	DURATION: MINUTES	DURATION: HOURS	DURATION: DAYS	DURATION: WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y☐ N☐ Motor vehicle accident
Y☐ N☐ Motorcycle accident
Y☐ N☐ Work related incident
Y☐ N☐ Playground incident
Y☐ N☐ Athletic endeavor
Y☐ N☐ Fight
Y☐ N☐ Fall
Y☐ N☐ Accident
Y☐ N☐ Illness
Y☐ N☐ Injury
Y☐ N☐ Unknown

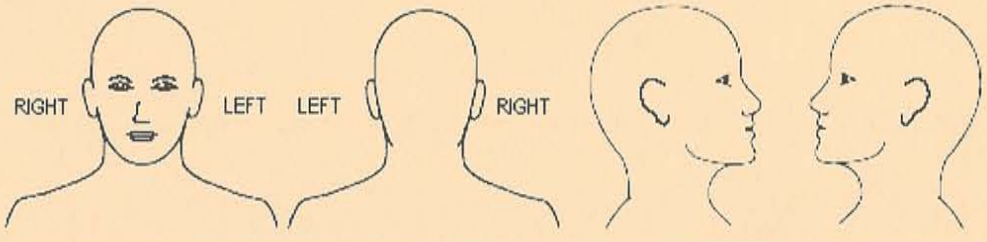
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



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. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

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DIBELLA DENTAL

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand DI BELLA DENTAL'S *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact DI BELLA DENTAL at any time to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that DI BELLA DENTAL restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand DI BELLA DENTAL is not required to agree to my requested restrictions, but if DI BELLA DENTAL does agree then DI BELLA DENTAL is bound to abide by such restrictions.

Patient Name_____

Relationship to Patient: _____

Signature:_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____