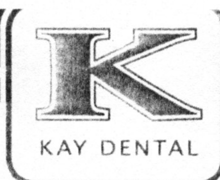
TMJ Disorders • Craniofa[illegible]l Pain



S[illegible]ep Apnea • Orthodontics

WELCOME

PATIENT INFORMATION

Patients Name ______________________________ Marital Status __________
Last First Middle Initial

Address ______________________________
Street City State Zip

Home Phone __________ Cell Phone __________ Work Phone __________

Social Security __________ DOB __________ E-mail __________

Employer __________ Occupation __________ Years Employed __________

Spouse's Name ______________________________
Last First Middle Initial

Spouse's Social Security __________ Spouse's DOB __________

Primary Insurance Company ______________________________

Address ______________________________
Street City State Zip

Phone __________ ID # __________ Group # __________

Insured's ______________________________
Name Soc. Sec.# DOB

Insured's Employer __________ Effective Date __________

Secondary Insurance Company ______________________________

Address ______________________________
Street City State Zip

Phone __________ ID # __________ Group # __________

Insured's ______________________________
Name Soc. Sec.# DOB

Insured's Employer __________ Effective Date __________

EMERGENCY CONTACT INFORMATION

Name ______________________________ Phone __________
Last First Middle Initial

Address ______________________________
Street City State Zip

Nearest Relative ______________________________
(not living with you)

ɟive my consent for Kay Dental to perform a complete dental and oral examination on the patient named above. X-rays that are necessary ill be taken. Any additional dental treatment received will be fully explained prior to its completion at each visit.

ısurance portions are an estimate based on the information released by my insurance company. IT DOES NOT GUARANTEE PAYMENT. am aware that the insurance coverage is a contract between me and my carrier. As a courtesy, claims may be filed on my behalf. Should ny dispute occur or if I fail to provide accurate information, I understand that I am financially responsible to the doctor for all treatment.

lease understand that your dental health care plan is a contract between you and your insurance company and not all services are a overed benefit under some contract agreements.

ou, as the patient, will be financially responsible for any charges not paid by your insurance company. A 24 hour cancellation notice is equired. A charge will be applied for cancellations or reschedules without 24 hour notice.

DENTAL HISTORY

Patient Name: Date of Birth:

DENTAL HISTORY Do you currently have or have you ever had any of the following?

Bleeding Gums	Y	N
Bad Taste / Odor	Y	N
Cavities / Fillings	Y	N
Clenching / Grinding of Teeth	Y	N
Cold Sores/Ulcers	Y	N
Daytime Drowsiness	Y	N
Deep Cleanings / Scalings	Y	N
Difficulty Opening Jaw	Y	N
Frequent Headaches	Y	N
Gum/Periodontal Disease	Y	N
High Blood Pressure	Y	N
Hot / Cold Sensitivity	Y	N
Hurt to Chew / Bite	Y	N
Injury to Head / Neck/Jaw	Y	N
Jaw get stuck / locked	Y	N
Loose / Mobile Teeth	Y	N
Oral Cancer / Biopsy	Y	N
Orthodontic Treatment	Y	N
Pain in Ears / Temples / CheeksSnoring	Y	N
Sleep Apnea	Y	N
TMJ/TMD Joint Pain	Y	N
Wisdom Teeth Extraction	Y	N

TMJ HISTORY

Do you currently have or have you ever had any of the following?

Jaw Pain?	Y	N
Difficulty Opening / Closing Jaw?	Y	N
Injury to Head / Neck?	Y	N
Jaw Getting Stuck / Locked?	Y	N
Frequent Headache?	Y	N
Unexplained Head / Neck Pain?	Y	N
Have you been treated for TMJ / TMD in the past?	Y	N

Other:

SLEEP HISTORY

Do you currently have or have you ever had any of the following?

Difficulty Falling Asleep or Staying Awake?	Y	N
Do you Snore?	Y	N
Are you frequently tired during the day?	Y	N
Are you aware or have you been told you stop breathing during sleep?	Y	N
Are you irritable for no reason?	Y	N
Do you doze when reading, sitting, driving, or working?	Y	N
Do you have decreased sex drive?	Y	N
Do you notice morning headaches?	Y	N

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize x-ray to be taken deemed necessary for diagnosis. I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

Patient's (or Guardian) Signature Date

TMJ Disorders • Craniofacial Pain

Sleep Apnea • Orthodontics

MEDICAL HISTORY

Patient Name: Date of Birth:

Do you have a personal physician? Y N Are you currently under a physician's care? Y N

Physician's Name: Date of Last Visit?

Reason:

HEALTH HISTORY

Anemia	Y	N
Arthritis, Rheumatism	Y	N
Artificial Heart Valves	Y	N
Artificial Joints	Y	N
Asthma	Y	N
Bleeding abnormally with extractions of surgery	Y	N
Cancer	Y	N
Chemical Dependency	Y	N
Chemotherapy	Y	N
Circulatory Problems	Y	N
Congenital Heart Lesions	Y	N
Cortisone Treatments	Y	N
Cough, persistent or bloody	Y	N
Daytime Drowsiness	Y	N
Depression	Y	N
Diabetes	Y	N
Emphysema	Y	N
Epilepsy / Seizure	Y	N
Fainting or Dizziness	Y	N
Frequent Night-time Urination	Y	N
Glaucoma	Y	N
Headaches / Migraine	Y	N
Heart Murmur	Y	N
Heart Problems	Y	N
Hemophilia	Y	N
Hepatitis Type _______	Y	N
Herpes	Y	N
High Blood Pressure	Y	N
HIV Positive/AIDS	Y	N
Jaw Pain	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Psychiatric Care	Y	N
Respiratory Disease	Y	N
Rheumatic Fever	Y	N
Seizures/Epilepsy	Y	N
Shingles	Y	N
Shortness of Breath	Y	N
Sinus Trouble	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Swelling of Feet or Ankles	Y	N
Thyroid Problems	Y	N
Tobacco Use	Y	N
Tuberculosis	Y	N
Ulcer	Y	N
Use CPAP?	Y	N
Women:		
Are you pregnant?	Y	N
Are you nursing?	Y	N

Other:

MEDICATIONS

List medications you are currently taking:

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Erythromycin
- ❑ Iodine
- ❑ Jewelry
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other:

COMMENTS:

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

First Update / Any Changes: Patient's (parent) Signature: Date

Second Update / Any Changes: Patient's (parent) Signature: Date