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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? ☐Google ☐ Facebook ☐ Instagram
☐ Dentist ☐ Primary Care Physician ☐ Doctor's office ☐ Friend or Coupon ☐ Our website
Please list referring doctor or dentist: Name: _____________________________________
City: ___________________________

Please write any family members/friends names that we can talk to about your billing account/or patient records on the lines below (per privacy laws we will be unable to discuss financial matters or your condition unless their name is on this list)

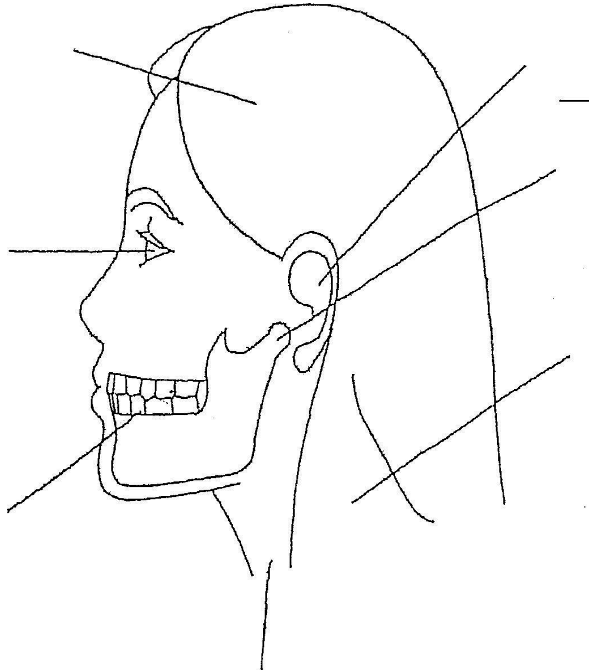
____

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. **Complaint:**______________________________
   Describe pain/complaint:______________________________
2. **Complaint:**______________________________
   Describe pain/complaint:______________________________
3. **Complaint:**______________________________
   Describe pain/complaint:______________________________
4. **Complaint:**______________________________
   Describe pain/complaint:______________________________

What is the main reason you are seeking treatment?

____

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/conditions? _______________ month/year

How often do they occur? ☐ constantly ☐ a few times a day ☐ a few times a week ☐ a few times a month

If not constant when do these symptoms typically occur? ☐ while asleep ☐ immediately upon waking ☐ morning ☐ throughout the day ☐ mid-day ☐ evening ☐ bedtime

What do you believe is the cause of your pain or condition? ☐ motor vehicle ☐ motorcycle accident ☐ work related incident ☐ illness ☐ athletic/sport endeavor ☐ fight ☐ accident ☐ injury ☐ unknown ☐ fall ☐ playground incident ☐ other/list: ___________

Have you had direct trauma/INJURY to your ☐ face ☐ head ☐ neck ☐ mouth ☐ teeth ☐ none

Date: __________ What happened: ____

____

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.

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.)

____

____

STRESS level on a scale of 1-10? _______**Reason why?** ____________________________________

____

ALLERGIES AND MEDICATIONS:

Do you have Allergies to any Medicine or Medical supplies? ☐Yes ☐No

Please 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?

☐ adenoids removed
☐ anxiety
☐ chronic fatigue
☐ depression
☐ difficulty concentrating
☐ dizziness
☐ frequent snoring
☐ jaw joint surgery
☐ muscle cramps/spasms
☐ needing extra pillows to help you breathe at night?
☐ osteoarthritis
☐ Parkinson's disease
☐ pregnancy
☐ sinus problems
☐ sleep apnea
☐ speech difficulties
☐ tonsils removed
☐ tooth clenching or grinding
☐ wake up unrefreshed

Primary care physician: ____________________________ city __________________ state ____

Primary dentist: ________________________________ city __________________ state ____

Please list any other doctors and therapist currently treating you:____

____

FAMILY HISTORY (family that is genetically/blood related)

☐ anxiety
☐ depression
☐ high blood pressure
☐ headaches/migraines
☐ blood disorders
☐ neurodegenerative diseases
☐ sleep apnea/snoring
☐ neuralgias/neuropathy
☐ heart disease
☐ bone disorders
☐ chronic infections (HIV, Hepatitis, recurring pneumonia, etc.)
☐ lung disease
☐ cancer
☐ diabetes
☐ long face appearance

SOCIAL HISTORY

☐ employed ☐ homemaker ☐ unemployed ☐ retired ☐ student part time ☐ student full time.
______# of hours/week.
Employer/school: ________________________________
occupation: ____________________________________
☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
Do you have children? ☐ yes ☐ no If yes, how many? _________
Are you caring for ☐ special needs child ☐ parents ☐ grandparents ☐ grandchildren ☐ adult child ☐ spouse
Any recent change in lifestyle? ☐ yes ☐ no what? _________________________________
Do you exercise regularly? ☐ yes ☐ no ☐ occasionally
Do you smoke? ☐ yes ☐ no **If yes**: ☐ 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? ☐ yes ☐ no **If yes how often:** ☐ daily ☐ with meals ☐ occasional ☐ social drinker
What time of day do you usually drink? ___Morning ___Afternoon ___Evening
Do you use caffeine? ☐ yes ☐ no what kind: ☐ soda ☐coffee ☐ tea ☐ pill form/energy drink
How often: ☐ daily ☐ weekly ☐ monthly **average amount and reason?** _________________

ACCIDENT? (LEGAL CASES ONLY)

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? _____________________
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:
____

Financial and Consent for Treatment Authorization Form

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize TMJ Therapy INC. (TMJI), its practices and providers including physicians, and other qualified personnel, including appropriately supervised assistants and students to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending practitioner. I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. TREATMENT OF MINOR CHILDREN: I understand minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at the time of services regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of TMJI unless I withdraw my consent in writing. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device, I also understand it is my responsibility to assure those accompanying me comply with this requirement.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized benefits is made on my behalf directly to the TMJI provider of service(s) furnished to me. I authorize TMJI to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to TMJI. I hereby authorize photocopies of this form to be valid as the original.

INSURANCE COVERAGE AND PAYMENT: I certify that I, and/or my dependent(s), have insurance coverage with the insurance company(ies) named in this document. This office will help prepare insurance forms and assist in making collections from your insurance company(s) and will credit or reimburse you as necessary 30 business days after treatment is final. This office cannot render services under the assumption charges will be paid by the insurance company. This office does not accept Medicare, Medicaid, or Tricare insurance plans.

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges occurred at time of service.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through TMJI practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a TMJI billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with TMJI's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by Advanced MD, a third-party business associate. I hereby consent to have my payment information collected and stored securely by Advanced MD.

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact TMJI's staff if I am unable to pay your balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. I also understand I may be discharged from the practice. ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $35.00 NSF fee.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. Patient care summaries may be sent to designated TMJI and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. TMJI and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record. I give permission to share my medical record among my healthcare providers. TMJI will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

ELECTRONIC PRESCRIBING: I understand that TMJI practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my TMJI providers and my pharmacy.

CELL PHONES: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the TMJI, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all TMJI practices and offices provide no facilities for safekeeping of valuables. I do hereby release TMJI from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a TMJI office or facility.

NOTICE OF PRIVACY PRACTICES: Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a)) I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment; a means of communication among the health professionals who may contribute to my health care; a source of information for applying my diagnosis and surgical information to my bill; a means by which a third-party payer can verify that services billed were actually provided; a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals. I have been provided with an opportunity to receive a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above.

Signature of Patient or Parent/Legal Guardian/Authorized Representative:
____ Date:______________________

Relationship to patient (if applicable)____