CRANIOFACIAL PAIN & JOINT REHABILITATION
TMJ THERAPY INC

Carl K McMillan, D.D.S., F.A.A.C.P.
Phone: 801-756-0900
355 E 50 S American Fork, UT 84003

WELCOME TO TMJ THERAPY

Patient name:_____ Email:_____
Address:_____City:_____State:_____Zip:_____
Home phone #:_____Cell phone#:_____
Birth date:_____Age:_____Gender: Male Female Other_____
Ethnicity/Race:_____Primary language:_____ Social security#:_____
Emergency contact:_____Relationship to you:_____Phone:_____
Person responsible for account payment: Self / Spouse / Parent / Other_____

Primary medical insurance:_____Member ID:_____
Insurance phone #:_____Insurance address:_____
Primary subscribers name:_____Birth date:_____
Employer_____Social security #:_____
Subscribers phone #:_____Subscribers address:_____
Patients relationship to the insurance primary subscriber: Self / Spouse / Child / Other_____

Secondary medical insurance:_____Member ID:_____
Insurance phone #:_____Insurance address:_____
Seconday subscribers name:_____Birth date:_____
Employer_____Social security #:_____
Subscribers phone #:_____Subscribers address:_____
Patients relationship to the insurance secondary 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, Medical office, Dental office, Friend or Flier

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 company(ies) 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. Today's Consultation Fee will be $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 and account.

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 RIGHTS OF PRIVACY PRACTICES

A copy may be obtained 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.

_____

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 of patient/responsible party Date Relationship to Patient

HEALTH HISTORY

Weight_____ Height_____

Do you or have you experienced any of the following:

- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bleeding easily
- ☐ Chronic fatigue
- ☐ Currently pregnant
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Frequent sore throat
- ☐ Migraines
- ☐ Memory loss
- ☐ Insomnia
- ☐ Hay fever
- ☐ Osteoporosis
- ☐ Jaw joint surgery
- ☐ Morning dry mouth
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Night time sweats
- ☐ Osteoarthritis
- ☐ Recent excessive weight gain
- ☐ Rheumatic fever
- ☐ Chronic sinus problems
- ☐ Shortness of breath
- ☐ Swollen stiff or painful joints
- ☐ Heart disorder
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Heart pacemaker
- ☐ Congestive heart failure
- ☐ Hepatitis
- ☐ Heartburn or sour tastes
- ☐ Injury to head neck or face
- ☐ Current mouth or teeth problems
- ☐ Prior orthodontics
- ☐ Thyroid problems
- ☐ Tonsillectomy
- ☐ Wisdom Teeth extraction
- ☐ (GERD) gastroesophageal reflux disease
- ☐ Do you need extra pillows to sleep at night
- ☐ Difficulty concentrating
- ☐ Muscle spasms

Allergies: List any medication which have cause an allergic reaction:

_____

Medications: please list any medications you are *currently* taking:

_____

_____

_____

FAMILY MEDICAL HISTORY

- ☐ Anxiety
- ☐ Cancer
- ☐ Heart disease
- ☐ Lung disease
- ☐ Sleep apnea/snoring
- ☐ Chronic infections
- ☐ Neurodegenerative diseases
- ☐ Blood disorder
- ☐ Depression
- ☐ High blood pressure
- ☐ Migraines/headaches
- ☐ Bone disorders
- ☐ Diabetes
- ☐ Long face appearance
- ☐ Neuralgias/neuropathy

SOCIAL HISTORY

Occupation/school:_____ Employer:_____
Hours worked:_____

Marital status: single____ married____ widowed____ divorced____ separated____
How long ago were you divorced separated_____

Do you have children: Yes____ No____ If yes how many:_____ Age range_____

Any recent changes in lifestyle: Yes___ No____ If yes, what:_____

Do you exercise regularly: Yes___ No___ Occasionally____

Do you consume alcohol: Yes___ No___ If yes how often: few times a week___ Daily___
Occasionally____

Do you consume caffeine: Yes___ No___ If yes how often: few times a week___ Daily___
Occasionally___ What type:_____

Do you take sedatives within 2-3 hours of bedtime: Yes___ No___
If so how often: few times a week___ Daily___ Occasionally____

Do you smoke or chew tobacco: Yes___ No___ what type: Cigarettes___ Vape___ Chew___
Medical marajana____ How long:_____ Amount per day_____

EPWORTH SLEEPINESS SCALE- a standardized questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation: 0= would never doze, 1=slight chance of dozing, 2=moderate chance of dozing, 3=high chance of dozing

It is important that you answer each question as best you can.

Sitting and reading	0___ 1___ 2___ 3___
Watching TV	0___ 1___ 2___ 3___
Sitting, inactive in a public place	0___ 1___ 2___ 3___
As a passenger in a car for an hour without a break	0___ 1___ 2___ 3___
Lying down to rest in the afternoon when circumstances permit	0___ 1___ 2___ 3___
Sitting down to rest in the afternoon when circumstances permit	0___ 1___ 2___ 3___
Sitting and talking to someone	0___ 1___ 2___ 3___
Sitting quietly after a lunch without alcohol	0___ 1___ 2___ 3___
In a car, while stopped for a few minutes in traffic	0___ 1___ 2___ 3___

Total score (add all scores above) _____

HISTORY OF PRESENT ILLNESS

Have you been medically diagnosed with any of the following:
Sleep apnea____ Migraine Headaches____ Tension headaches____ Fatigue___ Somnolence___

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a sleep center or sent home with an oximeter test?
Yes___ No___
Sleep center name and location:_____
Sleep study/home oximetry date:_____
Doctors name, location, and phone number of who ordered test:
_____

SLEEP AND HEALTH/ BERLIN SLEEP EVALUATION (please check the appropriate answer)

Do you snore or have you been told you snore: Yes___ No___
Has someone told you that you stop breathing or hold your breath while you sleep: Yes___ No___
When do you typically wake: _____
How long does it take for you to fall asleep:_____
Where do you most often sleep: Bed___ Couch___ Chair___ Floor___ Other:_____
How often do you wake at night:_____ Why:_____
Do you gasp in your sleep or suddenly wake gasping for breath: Yes___ No___
Do you have night time choking spells: Yes___ No___
Do you feel rested when you wake: Yes___ No___
Do you tire or fatigue easily throughout the day: Yes___ No___
Do you get swelling in your ankles or feet: Yes___ No___
Usually, when is the last meal or snack of the day: _____
Do you use any medication, drugs, alcohol, supplements to help you sleep: Yes___ No___
If yes, what do you use_____ how often_____

SLEEP HYGIENE/ENVIRONMENT

Do you like your mattress: Yes___ No___
Do you like your pillow: Yes___ No___
Do you like your sheets and or blankets: Yes___ No___
Is your room at a comfortable temperature when you go to bed: Yes___ No___
Does your room have a pleasant smell: Yes___ No___
Do you view any electronics in your room: Yes___ No___
Is your bedroom quiet at night time: Yes___ No___
Do you blow your nose and brush your teeth before bedtime: Yes___ No___
Do you have sources of dust above your bed: Yes___ No___

I attest that the above information is accurate and comprehensive. I understand that an incorrect or incomplete health history that I have provided may cause an incomplete or incorrect diagnosis, which may cause delayed results or even incorrect treatment:

Patients signature:_____Date:_____

TMJ Therapy, Inc Sleep Center

Carl K McMillan, D.D.S., F.A.A.C.P
355 E 50 S American Fork, UT 84003
Phone: 801-756-0900
Fax: 801-756-7290

PAP THERAPY INTOLERANCE FORM

Name:_____ Date:_____

Date of birth:_____Type of device: APAP____ CPAP____ BiPAP___

PAP intolerance (Positive Airway Pressure device)
If you have attempted treatment with a CPAP device, But could not tolerate it please fill out this paperwork:

I could not tolerate the PAP device due to:

- ☐ Mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise from the device disturbing sleep and or bed partner's roommates sleep
- ☐ PAP restricted movements during sleep
- ☐ PAP does not seem to be effective
- ☐ Pressure on the upper lip causing tooth related problems
- ☐ A latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the PAP apparatus at night
- ☐ Other list:_____

Signature:_____ Date:_____

I, the undersigned physician, verify the above referenced patient has attempted to comply with AASM standards for sleep therapy by using positive airway pressure therapy as prescribed. To my satisfaction, the patient has attempted to comply with PAP therapy but could not tolerate it. I recommend other options for therapy, including oral appliance therapy for treatment of obstructive sleep apnea.

Name:_____

Office name:_____

Office phone number:_____ Office Fax:_____

Signature:_____Date:_____

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SLEEP SURVEY BY THE BED PARTNER/ROOMATE

Patient name:_____Date of birth:_____

Your name:_____Todays date:_____

Your relationship to the patient:_____

We have found that the bed partner/roommate perspective is often more accurate when it comes to our patients' sleep health and habits. Please answer these questions about your bed partner/roommates as truthfully as you are able. If you don't know, write "IDK" for I don't know.

- ☐ Do they snore?
- ☐ Do they gasp for breath while sleeping?
- ☐ Do they stop breathing while sleeping?
- ☐ Do they toss and turn at night?
- ☐ Do they sweat excessively while asleep?
- ☐ Do they struggle waking in the morning?
- ☐ Do they struggle falling asleep?
- ☐ Do their sleep habits affect your health and sleep?
  If checked please explain:

  _____

  _____

What time do you usually go to bed:_____

How long does it take for them to fall asleep: _____

When do they usually wake up: _____

How many times to they get out of bed at night and why:_____

What would you like to see improve in regards to your bed partners/roomates sleep and sleep habits:

_____

_____

Thank you for your help. We are excited to help improve the health and sleep of both you and your bed partner/roommate. Please scan or photograph this document and email it to: office@tmjtherapyutah.com ASAP