TMJ Facial Pain Center

Patient Registration

Patient Full Name _____
Last First Middle

Address: _____
Street City/State Zip Phone

DOB (mm/dd/yyyy): _____ Age: ____ Gender (Circle): ☐ Male ☐ Female

How do you wish to be addressed (Nickname)? _____

Marital Status: ◯ Single ◯ Married/Living together ◯ Separated ◯ Divorced ◯ Widowed

Occupation: _____ (Circ ☐ Full Time ☐ Part time

Name of Spouse/Significant Other: _____

Spouses Occupation: _____ Phone: _____

In case of emergency contact: _____
Name ☐ Relationship to Patient ☐ Phone#

Other family members in this practice: _____

Whom may we thank for this referral? _____

Address: _____
Street City/State Zip Phone

Email: _____

The Referring person is a: ☐ Physician ☐ Dentist ☐ PhD ☐ Other: _____

In addition to the referring person above, please list anyone else that *should* receive a copy of your evaluation report (**Please include ***at least*** your current Dentist AND Primary Care Physician if not already listed above as referring doctor**):

Name: _____ (Circle): Select One Other_____
Address: _____
Street City/State Zip Code
Phone: _____ Fax: _____ Email: _____

Name: _____ (Circle): Select One Other_____
Address: _____
Street City/State Zip Code
Phone: _____ Fax: _____ Email: _____

Name: _____ (Circle): Select One Other_____
Address: _____
Street City/State Zip Code
Phone: _____ Fax: _____ Email: _____

Insurance/Billing

Who is responsible for this Account? ☐ Self ☐ Parent/Guardian: _____
☐ Other: _____

Dental Insurance Coverage

Insurance Company: _____ Ins. Phone: _____

Policy Holder Name _____ Policy Holder DOB: _____

Membership No (Often Same as Policy Holder SS#): _____

Group Name/Employer: _____ Group No: _____

Patient Relationship to Policy Holder: _____

Medical Insurance Coverage

Insurance Company: _____ Ins. Phone: _____

Policy Holder Name _____ Policy Holder DOB: _____

Membership No (Often Same as Policy Holder SS#): _____

Group Name/Employer: _____ Group No: _____

Patient Relationship to Policy Holder: _____

I authorize the Dentist, Dr. Robert Grill and/or practice personnel to perform procedures as may be necessary for proper care. I hereby authorize the use of my radiographs and/or photographs and diagnostic data for the use in seminars, publications or for our website.

I understand that my insurance carrier(s) or payer(s) of my benefits may pay less or none of the actual bill for services rendered. It is also my responsibility to understand the coverage's of my policy as TMJ Facial Pain Center is considered a non-participating provider; so this and any other information regarding my insurance plan is not available to them. I understand I am fully financially responsible for payments, in full, of all accounts at the time services are rendered. I understand that claims will be submitted to all insurances that are active at time services are rendered by either myself OR TMJ Facial Pain Center (as a patient courtesy). I also understand it is my responsibility, as the account holder, to correspond directly with the insurance company in an attempt to receive potential reimbursement for said services. I understand that there will be no refunds given to services already provided. I further agree to a $10 monthly rebilling charge to cover the costs of repeated billing procedures. I am also responsible for a $50 fee for any appointments missed, cancelled or rescheduled with less than 24 hours notice. As the patient, I agree that I am responsible for all collection fees.

I attest to the accuracy of the information given on this form:

Patient Name (Please print): _____Today's Date: _____

Patient or Parent/Guardian Signature: _____

Dental History

1. What is the purpose of your visit?

   _____

2. Are you aware of a problem?

   _____

3. How long since your last dental visit?

   _____

4. What was done at that time?

   _____

5. If not mentioned above, when was the last time your teeth were cleaned?

   _____

6. Present/Previous Dentist's name: _____
   Telephone No: _____

In the following questions, circle yes, no or don't know; whichever applies.

7. Have you made regular visits? Yes No Don't know
   How often? _____
8. Were full mouth x-rays or a panorex taken? Yes No Don't know
9. Have you had your wisdom teeth removed? Yes No Don't know
   If so, when and where? _____
10. Have you lost or had any other teeth removed? Yes No Don't know
11. Have they been replaced? Yes No Don't know
12. Do you clench or grind your teeth? Yes No Don't know
13. Does your jaw click or pop? Yes No Don't know
14. Have you ever experienced any pain or soreness in the muscles of your face or around your ear(s)? Yes No Don't know
15. Do you have frequent headaches, neck or shoulder pain? Yes No Don't know
16. Have you ever had orthodontic treatment? Yes No Don't know
17. Are any of your teeth sensitive to: ☐Cold ☐Hot ☐Sweets ☐Pressure ☐None

I certify the above information is complete and accurate:

Patients Signature: _____ Date: _____

Parent/Guardian Signature (if patient is under the age of 18): _____

Relationship to patient: _____

7600 Osler Drive - Suite 306 - Towson, Maryland 21204
Phone: 410-828-0800 Fax: 410-828-0874 Email: tmjbaltimore@gmail.com

Medical History

Date of last physical exam: _____

In the following questions, circle yes, no; whichever applies.

1. Are you under the care of specialists? Yes No
   If yes, please list names and telephone numbers: _____
   _____
2. Do you consider yourself in good health? Yes No
3. Have you ever bled excessively after a cut/injury? Yes No
4. Do you *have* or *have you had* any of the following (**Check all that apply**)?

☐ High blood pressure	☐ Low blood pressure	☐ Stroke
☐ Asthma	☐ Sinus troubles	☐ Artificial joints (i.e. hip, knee)
☐ Stomach problems	☐ Kidney problems	☐ Liver problems
☐ Hepatitis	☐ HIV	☐ AIDS
☐ Epilepsy/Seizures	☐ Glaucoma	☐ Thyroid Disease
☐ Diabetes	☐ Inflammatory diseases (i.e. arthritis, rheumatism)	
☐ Tuberculosis (TB)	☐ Blood disorder (i.e. anemia, leukemia	
☐ Heart murmur	☐ Damaged or artificial heart valves	
☐ Cardiac pacemaker	☐ Rheumatic fever/Rheumatic Heart Disease	
☐ Heart ailments (heart failure, heart disease, heart attack or angina pectoris)		
☐ Venereal Disease	☐ Cancer - Please explain: _____	

5. Have you ever had radiation treatment or chemotherapy for tumor growth or other condition? Yes No
   If yes, please explain: _____
6. Do you have any disease, condition or problem not listed? Yes No
   If so, please explain: _____
7. Have you ever had psychiatric care? Yes No
   If yes, please explain: _____
8. Do you use tobacco products? Yes No
9. Is there anything else we should know about your health that we have not covered in this form?
   _____
10. Would you like to speak to the doctor privately about any problems/concerns? Yes No

11. **For Women Only:**
    - Are you pregnant? ◯ Yes ◯ No
    - If yes, how far along? _____
    - If no, do you take any birth control pills? ◯ Yes ◯ No

- Current Medications -

Please include any prescriptions, over the counter medications & vitamins. If not taking any, please write "None"

	Drug Name	Dosage	Reason
1.			
2.			
3.			
4.			

12. Are you allergic or have you reacted adversely to any of the following (Check all that apply):

☐ Aspirin ☐ Penicillin ☐ Other antibiotics

☐ Codeine ☐ Latex ☐ Local anesthetics

☐ Other: _____

12. Do you have any other Allergies? ◯ Yes ◯ No If yes, please explain: _____

- Hospitalizations/Surgeries –

	Date	Purpose	Outcome
1.			
2.			
3.			
4.			

I certify that the above information is complete and accurate. I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis and treatment.

Patient Signature: _____ Date: _____

7600 Osler Drive - Suite 306 - Towson, Maryland 21204
Phone: 410-828-0800 Fax: 410-828-0874 Email: tmjbaltimore@gmail.com

SECTION A: PATIENT GIVING CONSENT Patient No (Office use): _____

Patient Full Name _____
Last First Middle

Address: _____
Street City/State Zip Phone

DOB (mm/dd/yyyy): _____ Primary Phone No: _____

Email: _____

SECTION A: TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this firm, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices to which we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person:*Monique Venable*
Phone: *410-828-0800* ***Fax:****410-828-0874* ***Email:*** *tmjbaltimore@gmail.com*
Address:*7600 Osler Drive - Suite 306 - Towson, MD 21204*

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____ have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent form is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____

Relationship to Patient: _____

TMJ Facial Pain Center

Patient Questionnaire

Patient Name _____
Last First Middle

DOB (mm/dd/yyyy): _____ Gender (Circle): ☐Male ☐Female

Marital Status: ☐ Single ☐ Married/Living together ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ (Circle) ☐Full Time ☐Part time

Name of Spouse/Significant Other: _____

Spouses Occupation: _____ Phone: _____

Is your chief complaint the result of an auto accident or work related injury? Select One

1.) Have you been or do you plan to be involved in legal action regarding your pain? Select One
If yes, please briefly explain: _____
_____

2.) Briefly describe your current pain problem. Why exactly are you seeking care?

_____
_____
_____

3.) Circumstances under which your pain problem(s) began:

a. ☐ Accident at work
b. ☐ Accident at home
c. ☐ Other accident
d. ☐ Following illness
e. ☐ Following Surgery
f. ☐ At work (no accident)
g. ☐ At home (no accident)
h. ☐ No known cause
☐ Other

4.) Briefly describe circumstances checked:

_____
_____

5.) What does your pain feel like? Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable.
Use only a **single word** in each appropriate category (the one that best applies).

Select One	Select One	Select One	Select One	Select One
1. Flickering	2. Jumping	3. Pricking	4. Sharp	5. Pinching
quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
		Lancinating		Crushing
Select One	Select One	Select One	Select One	Select One
6. Tugging	7. Hot	8. Tingling	9. Dull	10. Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
Searing	Stinging	Aching	Splitting	
			Heavy	
Select One	Select One	Select One	Select One	Select One
11. Tiring	12. Sickening	13. Fearful	14. Punishing	15. Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	cruel	
		Vicious		
Select One	Select One	Select One	Select One	Select One
16. Annoying	17. Spreading	18. Tight	19. Cool	20. Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawn	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

6.) Please indicate your average pain level on a scale of **0 (No pain)** to **10 (Worst Pain)** by circling or drawing an (X) over the corresponding number for the following:

a.) Your average Pain level: - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
b.) Your pain at its worst: - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
c.) Your pain at its least: - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
d.) Pain with Chewing: - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One

7.) Does your pain increase when you open wide? (Circle ☐Yes ☐No
If yes, Where is the pain?_____

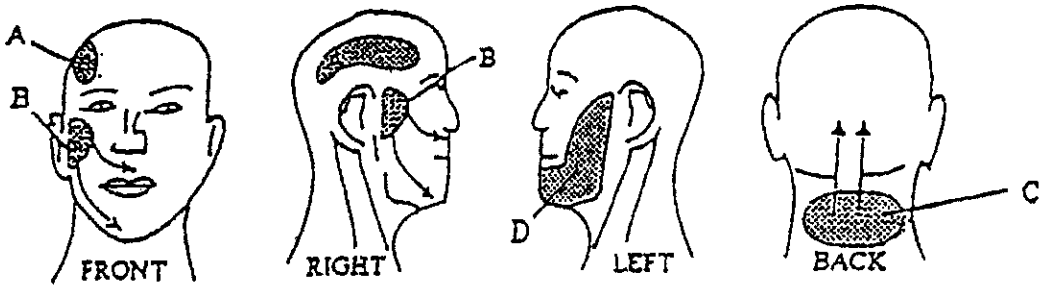
8.) How long, on average, can you go without pain; if at all? _____

9.) Describe your longest period of **complete** relief: _____
_____

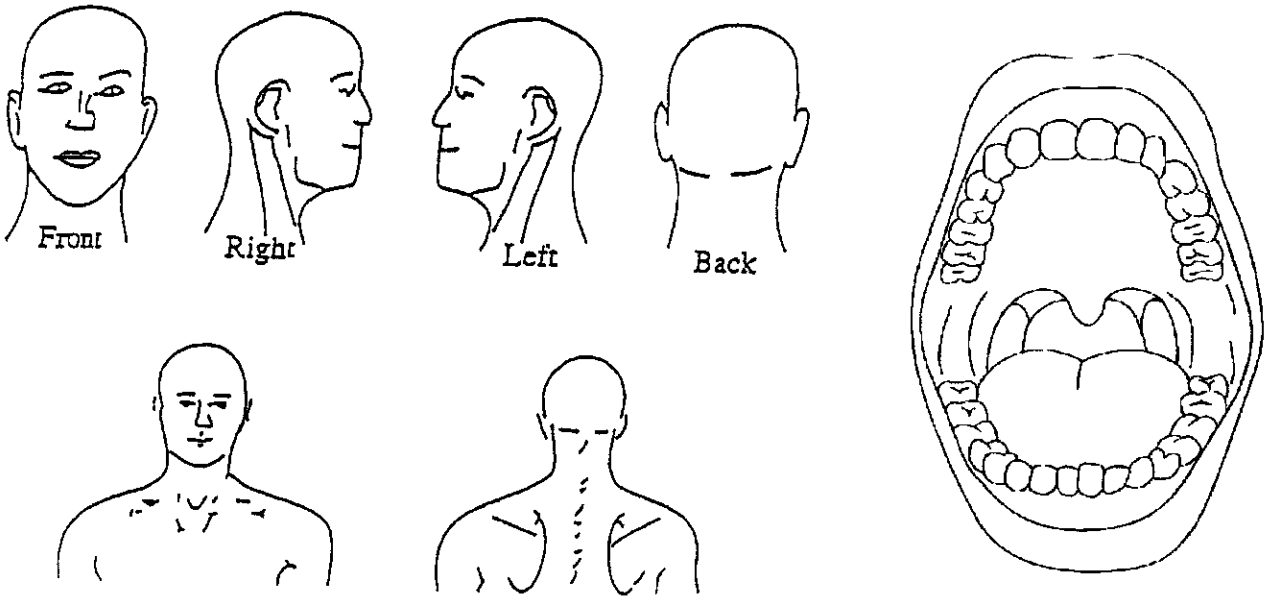
10.) ***In your opinion***, what do you think is the cause for your pain? _____
_____

11.) On the diagrams, following the example below, mark the area where you experience pain most frequently by shading, sketching, or outlining the painful areas in order of severity, with (A) being the mode severe or distressing. If the pain frequently moves, mark the starting point (worst area) with an (X) and draw an arrow to where the pain moves.

PLEASE DO NOT USE THIS EXAMPLE TO DRAW YOUR PAIN AREAS



Mark or Draw **YOUR** area(s) of pain on the following diagrams with a sharp pencil or blue pen:



12.) How long have you had these pain complaints? (Approximate date of original onset):

A. _____ B. _____ C. _____ D. _____

Has your pain increased, Decreased or remained the same since it began? (**Circle one**)

☐Increased ☐decreased ☐Remained the same

Comments:

_____

_____

_____

13.) Does anything else occur or do you notice anything else when the pain is severe? (Example: visual disturbances, nausea, perspiration, dizziness, tight chest, earache, etc.)

_____

_____

14.) Each of the following questions is about your experience of pain. These questions can be answered by circling a word or words. If you wish to describe more than one head/face problem, list them individually in the area below (problems, A, B, C, etc.) listing your WORST pain First. These are called your "Chief Complaint(s)": the problems for which you are seeking care here.

PROBLEM A _____

Intensity	Type of Pain	Frequency	Duration	Worst time of day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other_____	___Times/Day ___Times/Week ___Times/Month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While Eating/Talking As day progresses

PROBLEM B _____

Intensity	Type of Pain	Frequency	Duration	Worst time of day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other_____	___Times/Day ___Times/Week ___Times/Month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While Eating/Talking As day progresses

PROBLEM C _____

Intensity	Type of Pain	Frequency	Duration	Worst time of day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other_____	___Times/Day ___Times/Week ___Times/Month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While Eating/Talking As day progresses

PROBLEM D _____

Intensity	Type of Pain	Frequency	Duration	Worst time of day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other_____	___Times/Day ___Times/Week ___Times/Month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While Eating/Talking As day progresses

15.) If you pain is not constant, what events are most likely to make it start (what brings it on)?

Problem A _____
Problem B _____
Problem C _____
Problem D _____

16.) After pain has begun, what is most likely to make your general pain worse?
(**Examples**: chewing, stress, sleep, talking, opening mouth too wide, certain foods, weather, hot/cold food or drinks, exercise, lack of sleep, emotional upset, etc.)
LIST IN ORDER OF SEVERITY, WORST FIRST, FOR EACH PROBLEM

Problem A _____
Problem B _____
Problem C _____
Problem D _____

17.) What seems to ease your general pain or make it better?
(**Examples**: medication, sleep, vacation, massage, exercise, hot or cold compress, relaxation, moving or holding jaw in certain position, etc.)
LIST IN ORDER OF EFFECTIVENESS, MOST EFFECTIVE FIRST, FOR EACH PROBLEM

Problem A _____
Problem B _____
Problem C _____
Problem D _____

18.) Since the onset of your problem, has your participation in the following activities decreased? If so, estimate how much interference your pain has caused on a scale of **0 (No interference at all)** to **10 (No longer participate due to pain)**. Please circle or draw an (X) over the corresponding number for the following:

Physical exercise:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Leisure/Social:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Sleeping:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Relationships:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Housework/Chores:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Eating normal foods:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Select One
Talking:	- 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 – Select One

19.) Please check health care providers you have seen or consulted for your present condition:

☐ Acupuncturist	☐ ENT Physician	☐ Internist	☐ Psychiatrist
☐ Allergist	☐ Endocrinologist	☐ General Dentist	☐ Other: _____
☐ Anesthesiologist	☐ Family Physician	☐ Oral Surgeon	_____
☐ Chiropractor	☐ Gynecologist	☐ Neurologist	_____
☐ Physical Therapist	☐ Rheumatologist	☐ Neurosurgeon	_____
☐ Dermatologist	☐ Orthopedic Surgeon	☐ Surgeon	_____
☐ Pain/rehab Center	☐ Ophthalmologist	☐ Psychologist	_____

20.) What other treatments have you had for your chief complaint(s) and who was/is the treating doctor/provider? Please provide short, concise answers since details may be discussed at your next appointment:

Problem	**Treatment**	**Doctor/Provider** (Name & Specialty)

21.) In your opinion, which provider & treatment provided the best relief?

_____

22.) How often do you exercise? _____

23.) What type of exercise do you participate in? _____

_____

24.) When you use/consume the following, how much/often in a given day?

Coffee: ____ cups/day	Tobacco: ____cigarettes/day	Other: _____
Cola: ____ glasses/day	Beer: ____ 12 oz. cans/day	_____
Wine: ____ glasses/day	Liquor: ____ounces/day	_____

25.) Does your condition awaken you from or prevent sleep? (Circle) ☐Yes ☐No

If yes, please explain: _____

- Do you feel you get adequate sleep? ☐Yes ☐No
- Approximately how many hours per night? _____
- Do you feel rested after sleeping? ☐Yes ☐No
- Are you a restless sleeper? ☐Yes ☐No

26.) Have you experienced any of the following (Please check all that apply):

☐ Marriage	☐ Job Change	☐ Relocated/Moved
☐ Re-marriage	☐ Job Discharge	☐ Death of friend or loved one
☐ Separation from spouse	☐ Job dissatisfaction	☐ Serious illness of friend or loved one
☐ Divorce	☐ Financial troubles	☐ Abuse: Emotional, Physical or sexual
☐ Chemical/alcohol dependency	☐ Relocated/Moved	☐ Other: _____

27.) Are you generally: (Circle) calm & relaxed / tense & uptight?

A. Are you feeling depressed? ☐Yes ☐No

B. Are you feeling anxious? ☐Yes ☐No

C. Are there major stressors in your life? ☐Yes ☐No

If you answered 'Yes' to any of the above (A, B, C) please briefly explain:

A. _____

B. _____

C. _____

28.) Have you noticed any clenching or grinding your teeth or other oral habits that increase pain? (Circl☐Yes ☐No If yes, when? ☐Under Stress/Tension ☐While sleeping ☐Other Please describe: _____

29.) Do you feel that your alcohol consumption (beer, wine liquor) has increased in the past year as a result of your pain? (Circl☐Yes ☐No If yes, please explain: _____

30.) Have you ever been told you ***may*** have a problem with drugs or alcohol? (Circl☐Yes ☐No

31.) How would you describe your marital relationship now? Select One

a. ___Very satisfactory
b. ___ Satisfactory
c. ___ Unsatisfactory
d. ___Very unsatisfactory
e. ___ Prefer not to answer
f. ___ I am not married

32.) What are your expectations of your visit(s) with TMJ/Facial Pain Center?

_____

33.) Have you considered what you would do in the event that your pain would not be eliminated or significantly improved? _____

_____

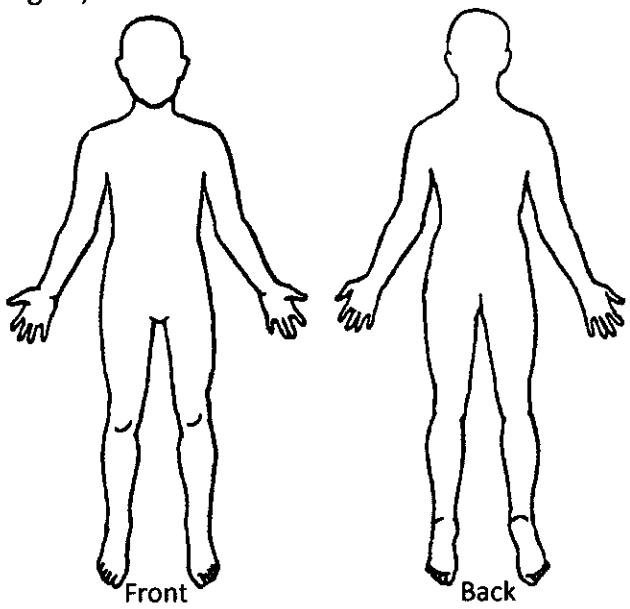
34.) What are you willing to do to improve? _____

_____

35.) What are you ***not*** willing to do to improve?_____

_____

36.) On the full body diagrams below, please indicate other areas where you commonly have significant pain not discussed in this questionnaire. Please number the areas in order of intensity, worst area being #1, and so on.



Please provide a brief description of each area, how long these pain conditions have been present, and if they were (in the past or currently) under the care of a physician:

#1.)_____
Describe How long? Under care of physician?

#2.)_____
Describe How long? Under care of physician?

#3.)_____
Describe How long? Under care of physician?

#4.)_____
Describe How long? Under care of physician?

#5.)_____
Describe How long? Under care of physician?

#6.)_____
Describe How long? Under care of physician?

Today's Date (mm/dd/yyyy): _____

Patient Name (Please print): _____

Patient Signature (or Parent/Guardian): _____

TMJ Facial Pain Center

Patient Questionnaire Addendum

Client shall be responsible for all collection or legal fees necessitated by lateness or default in payment.

Today's Date (mm/dd/yyyy): Click or tap here to enter text.

Patient Name (Please print): Click or tap here to enter text.

Patient Signature (or Parent/Guardian): Click or tap here to enter text.