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Enhance Your Smile…… Enhance Your Life

Patient Information

Date_____ Home Phone (____)_____ Cell Phone (____)_____

Name (last,first,middle)_____ SSN #_____

Address_____ E-Mail_____

City_____ State_____ Zip Code_____

Sex (circle) Male Female Age_____ Birth date _____

(Check) O Married O Widowed O Single O Minor O Separated O Divorced O Partnered for____ years

Patient Employer/ School_____Occupation_____

Employer/School Address _____Work Phone (____)_____

Whom may we thank for referring you? _____

In case of an emergency who should be notified?_____ Phone (____)_____

Dental Insurance

Person Responsible for Account (last,first,middle)_____

Relation to patient_____ Birth date_____ ID#/SSN #_____

Address (if different from patients) _____ Phone (____)_____

City_____ State _____ Zip_____

Person Responsible Employed By_____ Business Phone (____)_____

Insurance Company _____

Contract # _____ Group# _____ Subscriber# _____

Names of other dependents covered under this plan_____

Jaw Alignment Questionnaire

Section 1: Patient Information Date: _____

Patient Name: _____Phone: (Home)_____ (Cell)_____
Street Address: _____City:_____State:_____

Name of Spouse: _____Parent's Name (If Child) _____
If patient is a child over 18: School_____Year:_____

Dental Insurance Company: _____ID #_____
Subscriber's Name: _____Relationship to Patient_____
Employer: _____ Group # _____
Address for Claims Submission: _____

Medical Insurance Company:_____ID # _____
Subscriber's Name:_____ Relationship to Patient_____
Employer_____Group # _____
Address for Claims Submission _____

Who were you referred by? _____
What are your specific complaints? Please list from most to least important.

1. _____
2. _____
3. _____

When did you first experience the problem for which you are seeking help? Date: _____
Please list **ALL** physicians, therapists or health care providers you have consulted for this problem.

1. _____
2. _____
3. _____
4. _____
5. _____

In **YOUR** opinion, what initiated your present condition? Please identify any injuries or accidents.

_____
_____
_____
_____

What aspect of your condition concerns you most?_____
_____

Are you presently involved with any litigation? Please circle one. YES NO
If so, please list Attorney's name, address, and telephone number._____
_____

Headaches

Please circle the following that apply: Migraines Tension Headaches Other_____
Please describe how often: _____

Symptom Check list

Please circle if any of the following symptoms which may apply to you. L = Left R = Right

Top of head	L	R	Temples	L	R
Forehead	L	R	Behind the eyes	L	R
Back of head	L	R	Pain in neck	L	R
Pain in ear	L	R	Pain in shoulder	L	R
Ear congestion	L	R	Dizziness (Vertigo)	L	R
Ringing in ears	L	R	Pain in jaw joint	L	R
Facial pain	L	R	Clicking or popping	L	R
Grinding sound in joint	L	R			

Please choose yes or no on the following:

Spatial inability to open mouth	Yes	No	Is this: Constant or Sporadic
Face muscle twitch	Yes	No	
Difficulty in swallowing	Yes	No	
Difficulty breathing through nose	Yes	No	
Difficulty chewing	Yes	No	
Loose teeth	Yes	No	Specify area_____

Occlusal Habits:

__Clenching AM PM
__Teeth hit in front first
__Gum chewing
__Pencil biting
__Grinding on teeth AM PM
__Cheek biting
__Pipe smoking
__Nail biting

Other: _____

Postural Habits:

__Phone cradling
__TV watching
__Shoulder bag
__Leans chin on hand
__Heavy lifting

Other: _____

Doctors

Family Physician: _____Specialty: _____
Date of last complete medical exam: _____Phone #: _____
Address: _____
Diagnosis/Treatment Recommended:_____
Comments: _____

Other Pysician: _____Specialty:
_____
Date of last complete medical exam:_____Phone #: _____
Address: _____
Diagnosis/Treatment Recommended: _____
Comments: _____

Family Dentist: _____Specialty: _____
Date of last complete exam: _____ Phone #: _____
Address: _____
Diagnosis/Treatment Recommended:_____
Comments: _____

Weight: _____ Height: _____ DOB: _____

Medications Currently Taking

	Medications	Quantity	Reason
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please circle Yes or No and provide details if requested:

Are you currently under medical treatment: Yes No Treating Physician: _____

Explanation: _____

Do you have heart trouble?	Yes	No	
Do you have a pacemaker?	Yes	No	
Have you had rheumatic fever?	Yes	No	If so when: _____
Do you have high blood pressure?	Yes	No	How is it controlled? _____
Have you had pain in your chest?	Yes	No	
Do you get shortness of breath?	Yes	No	If so what triggers it: _____
Do your ankles ever swell?	Yes	No	
Have you ever been told you are anemic?	Yes	No	

(Continued)

Have you ever had a stroke?	Yes	No	
Do you have diabetes?	Yes	No	If so, how is it controlled? _____
Are you subject to fainting or dizziness?	Yes	No	
Do you have a nervous disorder?	Yes	No	
Are you allergic to any medication/drugs?	Yes	No	If so, what? _____
Do you have asthma?	Yes	No	
History of hay fevers?	Yes	No	
Seasonal allergies?	Yes	No	
Tonsil or adenoid problems?	Yes	No	
Have you had tonsil or adenoid surgery?	Yes	No	
Have you had tuberculosis?	Yes	No	If so when? _____
Have you had infectious hepatitis?	Yes	No	If so when? _____
Have you ever had a tumor or cancer?	Yes	No	If so when? _____
Have you ever had any major operations?	Yes	No	If so, what for? _____
Significant weight change in the last year?	Yes	No	If so, how much? _____
Is your diet medically supervised?	Yes	No	If so, for what purpose? _____

Do you take vitamins or mineral supplements?	Yes	No	
Do you become fatigued easily?	Yes	No	
Do you sleep well?	Yes	No	
Do you snore?	Yes	No	
Do you have trouble breathing when asleep?	Yes	No	
Do you sleep with the bed elevated?	Yes	No	
Do you frequently not eat breakfast?	Yes	No	
Do you take more than one alcoholic drink per day?	Yes	No	If so, how much? _____
Do you smoke tobacco?	Yes	No	

Problems of prolonged bleeding, either from a cut or a dental cleaning? Yes No
Have you ever been involved in a serious accident? Yes No
If so, explain:_____

Did the symptoms start after this accident? Yes No
If so, explain: _____

Are the symptom(s) due to an illness, injury or work related accident? Yes No
Place of accident or injury _____

Date and time of accident _____

Explanation _____

HAVE YOU HAD:

Recent radiographs? Yes No
If so, date/type _____

MRI or CT Scan Yes No
If so, date/reason why _____

Date of last eye exam _____

FOR WOMEN

Are you pregnant?	Yes	No
If so, expected delivery date: _____		
Are you actively trying to become pregnant?	Yes	No
Do you have a history of previous miscarriages?	Yes	No
Ovulate regularly?	Yes	No
Have you reached menopause?	Yes	No

If so, list supportive medication taken:

_____

_____

Have you had a hysterectomy?	Yes	No
Have you been diagnosed as having PMS?	Yes	No
Do your nails break easily?	Yes	No
Does cold weather bother you?	Yes	No

Please list any concerns you may have in addition to the questions stated above.

_____

_____

_____

_____

_____

_____

_____

_____

Office Financial Policy

Welcome to our practice and thank you for choosing us as your healthcare provider. We wish to advise you of our policies and procedures to prevent any misunderstandings regarding our services. Please read this carefully and if you have any questions, do not hesitate to ask a member of our team.

1. Please present your current insurance card at every visit. This is your verification of the correct insurance and consent to them on your family's behalf.
2. It is your responsibility to understand your benefit plan. Not all services provided by our office are covered by every plan. Any service not determined to be covered by your plan will be your responsibility. Our practice concern is for you and your dental health not your dental insurance.
3. If we do not participate in your insurance plan or you do not have insurance, payment in full is expected on the day services are rendered.
4. We will file a claim to your insurance carrier for you. Any amounts that are denied or unpaid will be billed to you. Most insurance plans will not pay the provider, therefore you will be responsible for the fee at the time of the service and your insurance company will reimburse you. We cannot guarantee the amount of the reimbursement that you will receive.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Any account balance outstanding greater than 30 days will be charged additional billing fees and subsequently forwarded to a collection agency.
6. A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
7. Our appointment times are limited. We require a 48 hour notice for cancelled appointments. Missed appointments may accrue a missed appointment fee without adequate notice.
8. Accepted forms for payment are cash, check, and debit. We also accept, CareCredit, Lending Club, MasterCard and Visa and American Express.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Head of Household/Patient: _____

Date: _____