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: _____ (Circle) 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): Dentist/Physician/Other_____
Address: _____
Street City/State Zip Code
Phone: _____ Fax: _____ Email: _____

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

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

Billing

I understand that I am fully responsible for payments, in full, of all accounts at the time of service rendered. I understand it is my responsibility as the account holder to correspond directly with my insurance company in an attempt to receive potential reimbursement. 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 cost of repeated billing procedures. I am also responsible for a $50 fee for any appointments missed, canceled or rescheduled with less than 24 hours' notice. As the patient, I agree that I am responsible for all collections fees.

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

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: _____

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: _____

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: _____