KNIGHT ORTHODONTICS

TMJ Patient Forms

Patient Information

Date:	DOB:
Name:	Title:
Address:	
Referred by:	

Major Reason for Evaluation

Describe what you think the problem is:
What do you think caused the problem?
Describe, in order (first to last), what you expect from your treatment:

General History

Are you presently under the care of a physician or have you been in the past year?	◯ Yes	◯ No
How would you describe your overall physical health?	Poor (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Excellent	
How would you describe your dental health?	Poor (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Excellent	
Dentist Name:	Last Appointment:	
Have you had any major dental treatment in the last two years?	◯ Yes	◯ No
Date(s) of Third Molar (Wisdom Tooth) Extraction(s):		

Facial Injury/Trauma History

Is there any childhood history of falls, accidents, or injuries to the face or head?
Is there any recent history of trauma to the head or face?
Is there any activity which holds the head or jaw in an imbalanced position?

TMD Treatment History

Have you ever been examined for a TMD problem before?	◯ Yes	◯ No
What was the nature of the problem?		
What was the duration of the problem?*		
Is this a new problem?	◯ Yes	◯ No
Is the problem...	◯ Getting Worse	◯ Staying the Same
Have you ever had physical therapy for TMD?	◯ Yes	◯ No
Have you ever received treatment for jaw problems?	◯ Yes	◯ No

Current Medications/Appliances

Degree of current TMD pain	No Pain ◯1 ◯2 ◯3 ◯4 ◯5 Severe Pain	
Frequency of TMD Pain:		
Is there a pattern related to the occurrence of pain?		
Are you taking medication for the TMD problem?	◯ Yes	◯ No
Are you aware of anything that makes the pain worse?		
Does your jaw make noise?	◯ Yes	◯ No
Does your jaw lock open?	◯ Yes	◯ No
Has your jaw ever locked closed or partially closed?	◯ Yes	◯ No
Have any dental appliances been prescribed?	◯ Yes	◯ No
Is there any additional information that can help us in this area?		

Current Stress Factors

Please check each factor that applies to you.

◯ Death of Spouse	◯ Financial Problems	◯ Death of Family Member	◯ Major Illnes or Injury
◯ Pregnancy	◯ New Person Joins Family	◯ Pending Marriage	◯ Taking on Debt
◯ Business Adjustment	◯ Fired from Work	◯ Marital Separation	◯ Divorce
◯ Marital Reconciliation	◯ Major Health Change in Family	◯ Career Change	◯ Other

Habit History

Do you clench your teeth together under stress?	◯ Yes	◯ No
Do you grind/clench your teeth at night?	◯ Yes	◯ No
Do you sleep with an unusual head position?	◯ Yes	◯ No
Are you aware of any habits or activities that may aggravate this condition?	◯ Yes	◯ No

Symptoms

Head Pain, Headaches, Facial Pain

- ◯ Left Forehead
- ◯ Right Forehead
- ◯ Left Temple
- ◯ Right Temple
- ◯ Migraine Type Headackes
- ◯ Cluster Headaches
- ◯ Maxillary Sinus Headaches
- ◯ Occipital Headaches
- ◯ Hair and/or Scalp Painful to touch

Eye Pain or Ear Orbital Problems

- ◯ Eye Pain
- ◯ Bloodshot Eyes
- ◯ Blurring of Vision
- ◯ Bulging Appearance
- ◯ Pressure Behind the Eyes
- ◯ Drooping of Eyelids
- ◯ Light Sensitivity
- ◯ Watering of the Eyes

Mouth, Face, Cheek, & Chin Problems

- ◯ Discomfort
- ◯ Limited Opening
- ◯ Inability to Open Smoothly

Teeth & Gum Problems

- ◯ Clenching/Grinding at Night
- ◯ Looseness and/or Soreness in Back of Teeth
- ◯ Tooth Pain

Jaw & Jaw Joint (TMD) Problems

- ◯ Jaw Locking Opened or Closed
- ◯ Grating Sounds
- ◯ Pain in Cheek Muscles
- ◯ Clicking, Popping Jaw Joint
- ◯ Uncontrollable Jaw/Toungue Movement

Pain, Ear Problems, Postural Imbalances

- ◯ Ear Pain Without Infection
- ◯ Balance Problems
- ◯ Diminished Hearing
- ◯ Clogged, Stuffy, Itchy Ears
- ◯ Hissing, Buzzing, Ringing, or Roaring

Throat Problems

- ◯ Swallowing Difficulties
- ◯ Sore Throat
- ◯ Laryngitis
- ◯ Feeling of Foreign Object
- ◯ Salivation
- ◯ Tightness of Throat
- ◯ Voice Fluctuation
- ◯ Tongue Pain
- ◯ Pain in the Hard Palate
- ◯ Frequent Coughing/Clearing Throat

Neck & Shoulder Pain

- ◯ Reduced Mobility of Motion
- ◯ Neck Pain
- ◯ Back Pain
- ◯ Stiffness
- ◯ Tired, Sore Neck Muscles
- ◯ Arm & Finger Tingling, Numbness, Pain

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Temporomandibular Joint Questionnaire

Patient's Name:			
Age:	Sex:	Date:	
Address:			
Do you have clicking, popping, or a grating noise in your right or left jaw joint?		◯ Yes	◯ No
When did you first notice the noise?			
Has the noise recently become more pronounced?		◯ Yes	◯ No
Do you have pain in or around the right or left jaw joint?		◯ Yes	◯ No
When did you first notice the noise?			
Has the noise recently become more pronounced?		◯ Yes	◯ No
When is the pain worse at?			
Does the pain sometimes feel like it is in your ear?		◯ Yes	◯ No
Do you think this problem has affected your hearing?		◯ Yes	◯ No
Does your jaw problem interfere with your normal activities?		◯ Yes	◯ No
Are you taking or have you taken medication for this problem?		◯ Yes	◯ No
Did anything occur that might be related to the onset of this problem?			
Do you have difficulty chewing?		◯ Yes	◯ No
Has your mouth ever locked open so that you were unable to close it? If so, please describe:			
Have you had problems with opening your mouth wide? If so, please describe:			
Are you aware of clenching your teeth?		◯ Yes	◯ No
Do you grind your teeth?		◯ Yes	◯ No
Have you had problems with other joints?		◯ Yes	◯ No
Have you had orthodontic treatment?		◯ Yes	◯ No
Have you had recent dental treatment?		◯ Yes	◯ No
Have you had X-rays taken for this problem?		◯ Yes	◯ No

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Patient Consent Form

I understand, that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____

Date: _____

Signature _____

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Patient Info Sheet

Patient Information

Date:	DOB:	Cell:
Name:		Email:
Address:		
Patient's Employer:	Patient's Dentist:	
Who referred you to Dr. Knight's office:		
Who will be financially responsible for this account:		
Relationship of responsible party to patient		
Name/Phone # of Primary Dental Insurance:		
Responsible Party's Social Security # and Birthdate:		
Insurance Claims Mailing Address:		
Responsible Party's Employer:		
Do you have a Secondary Insurance:		
2nd Responsible Party's Social Security #/ID/Birthdate:		
2nd Insurance Claims Mailing Address		

I hereby authorize the release of any medical information to process my insurance. I authorize payment to provider and understand I will be billed for any non-covered services.

Date: _____

Signature _____