Benage Dental Care

302 N Ridgeway Dr
817-641-6261
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TMD CLIENT INFORMATION

☐ MR ☐ MRS ☐ DR ☐ MS ☐ MISS | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

CLIENT'S NAME _____

AGE _____ DATE OF BIRTH_____ ☐ MALE ☐ FEMALE

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE # _____E-Mail Address_____

HOW LONG AT PRESENT ADDRESS? _____

IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.

PREVIOUS ADDRESS _____

CITY, STATE, ZIP _____

EMPLOYED BY _____

WORK PHONE # _____

IF THE CLIENT IS A MINOR, PLEASE FILL OUT THE BOX BELOW

☐PARENT ☐GUARDIAN NAME :_____

ADDRESS _____

CITY, STATE, ZIP_____

HOW LONG AT PRESENT ADDRESS? _____

SOCIAL SECURITY # _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

REGARDING INSURANCE: You are responsible for payment of your account. As a courtesy, we will submit your insurance claim. We will do all that we can to get the most in benefits reimbursed for you. Please be aware, we do not allow insurance companies to dictate our fees or what we consider the best treatment for our clients. We believe that our fees reflect the excellent standards we have set for your care.

INSURANCE COMPANY _____

GROUP NUMBER _____

PHONE NUMBER _____

INSURED'S NAME _____

EMPLOYER NAME _____

INSURED'S DATE OF BIRTH _____

I certify that the above information is correct to the best of my knowledge.

CLIENT/GUARDIAN SIGNATURE _____DATE_____

Please answer the following questions as completely and accurately as you can. ***Also***, ***please*** be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES, ***please*** explain on the line provided.

MEDICAL HISTORY:

1. YES NO Do you have a current medical problem? _____
2. YES NO Have you been told you have a heart murmur? _____
3. YES NO Do you have any heart problems? What kind? _____
4. YES NO Do you have ☐ High or ☐ Low Blood Pressure? Is it controlled? ☐ YES ☐ NO
5. YES NO Have you had rheumatic fever? When_____
6. YES NO Have you had pain in your chest or shortness of breath? _____
7. YES NO Do your ankles swell? _____
8. YES NO Has you physician ever told you that you are anemic? _____
9. YES NO Have you ever had a stroke? When? _____
10. YES NO Have you ever had epilepsy? _____
11. YES NO Do you have diabetes? Is it controlled? _____
12. YES NO Do you have fainting or dizzy spells? _____
13. YES NO Do you feel like your sense of balance has changed? _____
14. YES NO Do you have headaches? How often? Where? _____
15. YES NO Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? _____
16. YES NO Have you been advised not to take any medication? What? _____
17. YES NO Do you have asthma or hay fever? How is it controlled? _____
18. YES NO Have you ever had tuberculosis? When? _____
19. YES NO Have you ever had glaucoma? When? _____
20. YES NO Have you ever had hepatitis? When? _____
21. YES NO Do you have arthritis? How is it controlled? _____
22. YES NO Have you ever had a tumor or cancer? How was it treated? _____
23. YES NO Have you ever had any major surgeries? What kind? _____
24. YES NO Have you ever been injured in an accident? When? _____
25. YES NO Have you ever had a severe blow to the head? When? _____
26. YES NO Are your hands and/or feet cold? How often? _____
27. YES NO Is your diet medically supervised? For what purpose? _____
28. YES NO Do you have difficulty swallowing? _____
29. YES NO Do you have a feeling of something stuck in your throat? _____
30. YES NO Do you ever have any facial pain or pressure? Where? _____
31. YES NO Do you ever have any pain or pressure behind your eyes?_____
32. YES NO Are you aware of stiff neck muscles? How often? _____
33. YES NO Have you been in traction for a neck injury? When? _____
34. YES NO Have you ever had or been advised to have neck surgery?_____
35. YES NO Do you have back pain? Where? _____
36. YES NO Do your ears feel itchy, stuffy or congested? _____
37. YES NO Do you have difficulty with pain in your ears when changing altitude? _____
38. YES NO Do your ears ring, buzz or hiss? How often? _____

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CLIENT/GUARDIAN SIGNATURE _____DATE_____

39. YES NO Have you noticed any changes in your hearing? _____
40. YES NO Are you depressed? _____
41. YES NO Do you have emotional or anxiety/nervous problems? _____
42. YES NO Have you ever been treated for emotional or anxiety/nervous problems? _____
43. YES NO Have you □ gained or □ lost weight within the last year? How much? _____
44. YES NO Do you take more than one alcoholic drink per day? How many? _____
45. YES NO Do you use tobacco? How much? _____
46. YES NO Have you had any other serious illnesses, hospitalization or accidents? _____
Please explain:_____

Please list ALL medications and the dosage you are currently taking:

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

5._____ 6._____ 7._____ 8. _____

Please list any allergies to any **medications**:

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

Other allergies:

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

DENTAL HISTORY:

47. YES NO When was your last dental visit? _____
48. YES NO Have you been told that you have periodontal (gum) disease? _____
49. YES NO Do you have any existing problems with your teeth? Describe _____
50. YES NO Is any dental treatment planned? Describe _____
51. YES NO Do you bite your nails? _____
52. YES NO Have you ever had oral surgery? _____
53. YES NO Have you lost any teeth? From what cause? _____
54. YES NO Have the teeth been replaced? When? _____
55. YES NO Have you ever had orthodontic treatment? When? _____
56. YES NO Have you ever had extensive dental treatment? When? _____
57. YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?
Where? _____
58. YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO

TMJ HISTORY

59. YES NO Do you ever have a burning or painful sensation in your mouth? _____
60. YES NO Do you get popping, clicking, or grinding noises when you open or close? _____
61. YES NO Do you ever awaken with an awareness of your teeth or jaws? _____
62. YES NO Are you aware of clenching during the daytime? How often? _____
63. YES NO Have you ever been told you grind your teeth during sleep? _____
64. YES NO Do you have trouble opening your mouth widely? _____
65. YES NO Does your jaw ever lock open or closed? How often? _____
66. YES NO Do you feel your bite is different, unstable or uncomfortable? _____
67. What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? _____
68. YES NO If you sought treatment for a TMJ problem, did it help? _____
69. YES NO Do you or have you had any pain in any of the following areas? (circle)
Jaw Ear Face Neck Teeth Head Other _____
70. YES NO Do your jaw problems affect your ability to chew? _____
71. YES NO Has your diet changed due to your jaw problems? Describe_____
72. YES NO Do your joint noises affect others while eating? _____

I certify that the above information is correct to the best of my knowledge.

CLIENT/GUARDIAN SIGNATURE _____DATE_____

FAMILY HISTORY:

73. YES NO Do you have children. What are their ages? _____
74. YES NO Does your partner help you? _____
75. YES NO Do you have houseguests? _____
76. YES NO Does your job satisfy you? _____

FOR WOMEN:

77. YES NO Are you pregnant? Expected delivery date? _____
78. YES NO Do you have a history of miscarriages? When? _____
79. YES NO Have you reached menopause? _____

SLEEP, SNORING AND APNEA HISTORY

80. YES NO Do you become easily fatigued? At what time of day? _____
81. YES NO Do you have problems with insomnia? _____
82. YES NO Do you sleep well? How long? _____
83. YES NO Do you dream? How often? _____
84. YES NO Do you have trouble falling asleep or staying asleep? Which_____
85. YES NO Do you snore or have you been told you do? _____
86. YES NO Do you wake up with a headache? _____
87. YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain? _____
88. YES NO Do you often fall asleep reading or watching television? _____
89. YES NO Have you fallen asleep during the day against your will? _____
90. YES NO Have you had to pull off the road while driving due to sleepiness? _____
91. YES NO Have you been more irritable and short tempered?_____
92. YES NO Have you felt that your memory and/or intellect is impaired? _____
93. YES NO Have you been told that you stop breathing while asleep? _____
94. About how many times per night do you wake up? _____
95. What time do you normally go to bed?_____ Get up in the morning? _____
96. Of the hours you are in bed, about how many hours are you asleep? _____
97. Would you rate the quality of your sleep as ☐ Good ☐ Fair ☐ Poor?
98. YES NO Do you have difficulty breathing through your nose? _____
99. Present body weight:_____lbs. Height_____ft. _____inches.
100. YES NO Have you been diagnosed or treated for a sleep disorder? When_____
101. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder?
102. YES NO Have you ever had an evaluation at a sleep center?
    Sleep Center Name:_____
    Location: _____
    Sleep Study Date: _____
103. What professional advice or treatment have you received about your snoring or sleep apnea?
    _____
    _____
104. YES NO If you sought treatment for a sleep disorder, did it help?_____
    _____

I certify that the above information is correct to the best of my knowledge.

CLIENT/GUARDIAN SIGNATURE _____DATE_____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

***This** refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.*

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____	**0** = Would **never** doze
Watching TV _____	
Sitting inactive in a public place (e.g. A theater or a meeting) _____	**1** = **Slight** chance of dozing
As a passenger in a car for an hour without a break _____	
Lying down to rest in the afternoon when circumstances permit _____	**2** = **Moderate** chance of dozing
Sitting and talking to someone _____	
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in traffic	**3** = **High** chance of dozing

IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION AND TURN THE PAGE!

CPAP HISTORY:

YES NO Do you wear a CPAP device **successfully** during sleeping?
How many hours per night do you wear your CPAP?

_____

YES NO Have you tried other therapies for your sleeping disorder?
Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.)_____

_____

If you are unable to wear a CPAP device, please check below reasons for your difficulty.

- ☐ Mask Leaks
- ☐ Mask Uncomfortable/Device Uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs my sleep and/or bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex Allergy
- ☐ Claustrophobia
- ☐ Other_____

I certify that the above information is correct to the best of my knowledge.

CLIENT/GUARDIAN SIGNATURE _____DATE_____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

ORDER	FREQUENCY	INTENSITY
1. Please order your *chief complaints* by number: **#1** being the 1st or most important, **#2** the 2nd important, **#3** the 3rd less important, **#4, #5, #6…etc**. *(List all please)*	**2. Rate your chief complaints for frequency as follows:** **1**= Seldom **2**= Occasional **3**= Frequent **4**= Every Day	**3. Rate the intensity of each complaint ordered on a scale from 0-10.** **0**= No Pain to **10**= Most severe pain

Chief Complaint	ORDER	Frequency (1-4)	Intensity 0-10)	*For Office Use Only*
Jaw clicking/popping				
Jaw joint noises				
Jaw locking				
Muscle twitching				
Limited mouth opening				
Dizziness				
Headaches				
Visual disturbances				
Jaw pain				
Facial pain				
Ear pain				
Back pain				
Eye pain				
Neck pain				
Shoulder pain				
Pain when chewing				
Throat pain				
Ear congestion				
Sinus congestion				
Ringing in the ears				
Fatigue				
Frequent heavy snoring				
Snoring which affecting sleep of others				
Significant daytime drowsiness				
Stop breathing when sleeping				
Difficulty falling asleep				
Gasping when waking up				
Nighttime choking spells				
Feeling unrefreshed upon waking				
Morning hoarseness				
Swelling in ankles or feet				
Other_____				
Other_____				

I certify that the above information is correct to the best of my knowledge.

CLIENT/GUARDIAN SIGNATURE _____DATE_____

When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

ATTORNEY INFORMATION

Are you involved in a lawsuit regarding your condition? □ YES □ NO

If you have an attorney representing you, please complete the following:
Attorney's Name _____
Paralegal _____
Phone Number _____
Address _____
City, State, Zip _____

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire. _____

I certify that the above information is correct to the best of my knowledge.
CLIENT/GUARDIAN SIGNATURE _____ DATE_____

Please take a moment to read our office policies and feel free to ask any questions you may have.

CONSENT FOR TREATMENT

I hereby authorize Benage Dental Care and designated team to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Benage Dental Care and Team to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated on the following page. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. **I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.**

FINANCIAL POLICY

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, check, MasterCard/Visa/Discover and American Express. For our clients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Client Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 1.5% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. I understand that a credit history may be secured. Our returned check fee is $50.00

Our goal is to eliminate "billing surprises" so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

APPOINTMENTS

Should you need to cancel an appointment, we ask that you notify our office at least **48 hours in advance**. If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you will be charged a missed appointment fee of **$200 per hour.**

I have read and understand the Benage Dental Care Consent for Treatment, Financial and Appointment policies. I have had all of my questions regarding these issues answered by a Client Coordinator and agree to abide by these policies.

Client Signature: _____ Date: _____

Client/
Responsible Party Signature: _____ Date: _____

Relationship: _____ Witness: _____

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. *Please initial* if you want us to send them a report from your visit.

Initial _____ **FAMILY PHYSICIAN**

Name _____
Address _____
_____
Phone _____

Initial _____ **DENTIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **CHIROPRACTOR**

Name _____
Address _____
_____
Phone _____

Initial _____ **PHYSICAL THERAPIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **ENT**

Name _____
Address _____
_____
Phone _____

Initial _____ **CARDIOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **ALLERGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **NEUROLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PSYCHIATRIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PSYCHOLOGIST**

Name _____
Address _____
_____
Phone _____

Initial _____ **PULMONOLOGIST**

Name _____
Address _____
Phone _____

Initial _____ **OTHER**

Name _____
Address _____
Phone _____

I certify that the above information is correct to the best of my knowledge.

CLIENT NAME (PRINTED) _____

CLIENT/GUARDIAN SIGNATURE _____DATE_____