Patient Health Questionnaire

PATIENT INFORMATION

Date of completion

TMNDX™

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

Name: _____
First Middle Initial Last

Age: _____ **Date of Birth:** _____

Referred by: _____ ☐DDS ☐MD ☐ENT ☐DC ☐Other

Location and/or Phone Number of Healthcare Provider: _____

Patient Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Alternate Contact Number:** _____

Type of Employment: _____

Responsible Party (if different than Patient): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Family Dentist: _____ **Address and/or Phone:** _____

Family Physician: _____ **Address and/or Phone:** _____

Reason(s) for this appointment: ☐Pain ☐Sleep/Airway ☐Orthodontics ☐Unknown

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?

NOTE-PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9.

	Recent	Chronic (6 mo.+)
___ Headache pain	☐	☐
___ Ear pain	☐	☐
___ Jaw pain	☐	☐
___ Pain when chewing	☐	☐
___ Facial pain	☐	☐
___ Eye pain	☐	☐
___ Throat pain	☐	☐
___ Neck pain	☐	☐
___ Shoulder pain	☐	☐
___ Back pain	☐	☐
___ Limited ability to open mouth	☐	☐
___ Jaw joint locking	☐	☐
___ Jaw joint noises	☐	☐
___ Ear congestion	☐	☐
___ Sinus congestion	☐	☐
___ Dizziness	☐	☐
___ Tinnitus (ringing in the ears)	☐	☐
___ Muscle twitching	☐	☐
___ Vision problems	☐	☐
___Other: _____	☐	☐

	Recent	Chronic (6 mo.+)
___ Kicking or jerking leg repeatedly	☐	☐
___ Swelling in ankles or feet	☐	☐
___ Morning Hoarseness	☐	☐
___ Dry mouth upon waking	☐	☐
___ Fatigue	☐	☐
___ Difficulty falling asleep	☐	☐
___ Tossing and turning frequently	☐	☐
___ Repeated awakening	☐	☐
___ Feeling unrefreshed in the morning	☐	☐
___ Significant daytime drowsiness	☐	☐
___ Frequent heavy snoring	☐	☐
___ Affects sleep of others	☐	☐
___ Gasping when waking	☐	☐
___ Told that "I stop breathing" during sleep	☐	☐
___ Night-time choking spells	☐	☐
___ Unable to tolerate C-Pap	☐	☐
___ Tooth grinding	☐	☐
___ Teeth crowding	☐	☐

Do you have concerns in any of these areas: ☐ General Appearance ☐ Ability to Function ☐ Overbite ☐ Smile

Other Comments: _____

_____

Do any of the above complaints or concerns affect your daily life? _____

_____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?

_____

_____

Patient Signature: _____ Date: _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

- ☐ Yes ☐ No Heart Disorder/ Heart Attack
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Mitral Valve prolaps
- ☐ Yes ☐ No Heart Pacemaker
- ☐ Yes ☐ No Heart Palpitations
- ☐ Yes ☐ No Heart Valve Replacement
- ☐ Yes ☐ No Irregular Heartbeat
- ☐ Yes ☐ No Blood Pressure ☐ High ☐ Low
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Bleeding Easily
- ☐ Yes ☐ No Bruising Easily
- ☐ Yes ☐ No Cancer of _____
  Chemo ☐ Radiation ☐
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Birth Defects
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No Gastroesophpgeal Reflex (Gerd)
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No History of Substance Abuse
- ☐ Yes ☐ No Hypoglycemia
- ☐ Yes ☐ No Huntington's Disease
- ☐ Yes ☐ No Kidney Disease
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Leukemia
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No Meniere's Disease
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Muscular Dystrophy
- ☐ Yes ☐ No Neuralgia
- ☐ Yes ☐ No Osteoarthritis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Ovarian Cyst
- ☐ Yes ☐ No Parkinson's Disease
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Rheumatoid Arthritis
- ☐ Yes ☐ No Scarlet Fever

- ☐ Yes ☐ No Thyroid Problem
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Intestinal Disorder
- ☐ Yes ☐ No Nervous System Disorder
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Skin Disorder
- ☐ Yes ☐ No Urinary Tract Disorder
- ☐ Yes ☐ No Chronic Fatigue
- ☐ Yes ☐ No Fibromyalgia
- ☐ Yes ☐ No Cold hands and feet
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Difficulty concentrating
- ☐ Yes ☐ No Difficulty breathing at night for sleep
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Fainting
- ☐ Yes ☐ No Fluid Retention
- ☐ Yes ☐ No Frequent colds/flu
- ☐ Yes ☐ No Frequent cough
- ☐ Yes ☐ No Frequent ear infections
- ☐ Yes ☐ No Frequent sore throat
- ☐ Yes ☐ No Frequent awaking at night - number of times _____
- ☐ Yes ☐ No Hearing impairment
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Hay Fever
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Muscle aches
- ☐ Yes ☐ No Muscle fatigue
- ☐ Yes ☐ No Muscle spasms
- ☐ Yes ☐ No Muscle tremors
- ☐ Yes ☐ No Poor circulation
- ☐ Yes ☐ No Psychiatric Care
- ☐ Yes ☐ No Recent weight gain
- ☐ Yes ☐ No Recent weight loss
- ☐ Yes ☐ No Sinus problems
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Slow healing sores
- ☐ Yes ☐ No Speech difficulties
- ☐ Yes ☐ No Swollen, stiff or painful joints
- ☐ Yes ☐ No Tired muscles

Additional Information _____

_____

SURGICAL HISTORY *Have you had any of the following:*

- ☐ Yes ☐ No General Anesthesia
- ☐ Yes ☐ No Adenoids removed
- ☐ Yes ☐ No Tonsils removed
- ☐ Yes ☐ No Jaw Joint Surgery
- ☐ Yes ☐ No Orthognathic Surgery
- ☐ Yes ☐ No Oral Surgery

Removal of third molar (wisdom teeth) ☐ Other ☐

- ☐ Yes ☐ No Other surgery _____ *please list below*

Other types of surgery _____

_____

_____

_____

Patient Signature: _____ Date: _____

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

☐ Anesthetics	☐ Codeine	☐ Penicillin
☐ Antibiotics	☐ Iodine	☐ Plastic
☐ Aspirin	☐ Latex	☐ Sedatives
☐ Barbituates	☐ Metals	☐ Sulfa

Other: _____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____

HEALTH AND MEDICAL HISTORY

☐ Yes ☐ No Are you currently pregnant?

☐ Yes ☐ No Have you sustained injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth ☐ Other: _____

☐ Yes ☐ No Do you drink 4 or more cups of coffee per day?

☐ Yes ☐ No Do you smoke tobacco?

☐ Yes ☐ No Have you had prior orthodontic treatments?

☐ Yes ☐ No Consume alcohol or take sedatives for sleeping

☐ Yes ☐ No Trouble breathing through nose

Patient Signature: _____ **Date:** _____

CURRENT SYMPTOMS

Head Pain

Location (L=Left R=Right B=Bilateral)	*Recent*	*Chronic* (over 6 mo.)	*Severity* Mild	Mod	Severe	*Duration* Min.	Hrs.	Days	*Frequency* Occasional	Frequent	Constant
L R B Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Parietal (Top of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Occipital (Back of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Temporal (Temple area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain

☐ L ☐ R Jaw pain with opening
☐ L ☐ R Jaw pain when chewing
☐ L ☐ R Jaw pain at rest

Jaw Joint Sounds

☐ L ☐ R Jaw sounds with opening
☐ L ☐ R Jaw sounds when chewing
☐ L ☐ R Jaw sounds at rest

Jaw Locking

☐ Yes ☐ No Jaw locks closed
☐ Yes ☐ No Jaw locks open

Jaw Joint Symptoms

☐ Yes ☐ No Teeth clenching ☐ Day ☐ Night
☐ Yes ☐ No Teeth grinding ☐ Day ☐ Night

Eye Related Conditions

☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Double vision
☐ Yes ☐ No Eye pain
☐ Yes ☐ No Pain or pressure behind the eyes
☐ Yes ☐ No Extreme sensitivity to light (photophobia)
☐ Yes ☐ No Wear of glasses or contact lenses

Ear Related Conditions

☐ L ☐ R Buzzing in the ears
☐ L ☐ R Ear congestion
☐ L ☐ R Ear pain
☐ L ☐ R Hearing loss
☐ L ☐ R Itchiness or Stuffiness in ears
☐ L ☐ R Pain behind the ear
☐ L ☐ R Pain in front of the ear
☐ L ☐ R Recurrent ear infections
☐ L ☐ R Ringing in the ear (Tinnitus)

Throat Related Conditions

☐ Yes ☐ No Chronic sore throat
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Swollen glands
☐ Yes ☐ No Thyroid enlargement
☐ Yes ☐ No Tightness in throat
☐ Yes ☐ No Constant feeling of a foreign object in throat

Neck Related Conditions

☐ Yes ☐ No Limited movement of neck
☐ Yes ☐ No Neck pain
☐ Yes ☐ No Numbness in hands or fingers
☐ Yes ☐ No Swelling in the neck

Patient Signature: _____ Date: _____

Shoulder Related Conditions

☐ Yes ☐ No Shoulder pain
☐ Yes ☐ No Shoulder stiffness
☐ Yes ☐ No Tingling in hands or fingers

Back Related Conditions

☐ Yes ☐ No Back pain - lower
☐ Yes ☐ No Back pain - middle
☐ Yes ☐ No Back pain - upper
☐ Yes ☐ No Sciatica
☐ Yes ☐ No Scoliosis

Mouth and Nose Related Conditions

☐ Yes ☐ No Dry mouth
☐ Yes ☐ No Chronic sinusitis
☐ Yes ☐ No Frequent snoring
☐ Yes ☐ No Burning tongue
☐ Yes ☐ No Broken teeth
☐ Yes ☐ No Frequent biting of the cheek

Sleep Conditions

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions ☐ Side ☐ Back ☐ Stomach ☐ Varies
Is it easy to fall asleep? ☐ Yes ☐ No
Do you feel rested upon AM waking? ☐ Yes ☐ No
Stopped breathing during sleep? ☐ Yes ☐ No
Average hours of sleep per night? _____
Do you wake often during the night? ☐ Yes ☐ No
Gasping or Choking during sleep? ☐ Yes ☐ No
Have you ever had a Sleep Study (PSG)? ☐ Yes ☐ No
Result was _____

HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptoms first occur? _____

☐ Yes ☐ No **Does any family member have the same or similar problem? If yes, please explain.** _____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

If yes, please complete Trauma History Section, enclosed as a separate form.

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor):_____ Date: _____

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

Please answer the following questions.

1.Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2) No (0) _____

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2) No (0) _____

b) You are driving or stopped at a light?

Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

TOTAL _____

Score

9 points or more	**6-8 points**	**5 points or less**
Refer to sleep specialist or order sleep study	Gray area, use clinical judgment	Low probability of sleep apnea

AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name **Location/Phone**

_____

_____

_____

_____

_____

_____

_____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____

Consent of Services

Please initial in each _____ below:

_____ **Reserved Appointment Time:** Your appointment time is reserved especially for you. While we understand that certain emergencies may arise, we ask that you provide **3-business days notice** for cancellations or changes to your reserved appointment.

_____ **Dental Insurance:** In order to maintain our high standard of care Fairlington Dental does not participate with insurance plans. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms in their entirety. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We are happy to assist with dental / medical appeals should a charge be denied for payment, with the exception of exclusions by your dental / medical plan.

_____ **Medicare Patients:** Our office has **opted out** of Medicare. By signing below, you agree to enter into a private contract with Dr Michael Rogers for services rendered. Upon signing below and entering this contract, you agree not to file Medicare for reimbursement or receive reimbursement from Medicare for the services rendered at our office.

_____ **Payments:** Payment is expected at the time of service unless **prior** arrangements have been made. We accept American Express, MasterCard, Visa, Discover, Cash and Checks. We offer a 5% courtesy for any appointments exceeding $1000 when they are prepaid one week prior to the date reserved. We also offer flexible payment arrangements including interest free payments up to a year. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. Returned checks will be subject to an additional fee of $30 per return. After a returned check, payment will need to be made with a credit card, cash, money order. No checks can be accepted after a returned item.

I understand that the fee estimates for dental care can only be extended for a period of **one month** from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home, on my cell phone, by email or at my work to discuss matters related to this form.

Dental Benefit Explanation

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs and we assume that you are as concerned as we are about maintaining optimal dental health. Our entire team is pleased that you have insurance benefits to help you and your family with the cost of dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together to ensure these benefits.

Do you accept my insurance? We will gladly help file your insurance for reimbursement each time services are rendered. We are a non-participating office with all plans. As a courtesy, each time services are rendered we will generate a dental claim form, attach the necessary x-rays, narratives and/or photos and ask that you mail it to your insurance company. Your insurance company will process the claim based on the plan your employer has chosen. The payment will be mailed directly to you for reimbursement. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from employer to employer, sometimes even so within a company. It has absolutely nothing to do with the level of service provided by us and the fee charged for our services. An often-misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. These fee ceilings were often set 10-15 years ago. Your employer decides the level of coverage and benefits with your insurance company prior to the time that services are rendered by our office. Please check your plan for waiting periods or specific exclusions. We will be happy to provide dental codes and pricing upon request.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

FAIRLINGTON DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Fairlington Dental. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary treatment, payment or office procedures.

_____ _____
Print Name Address

_____ _____
Signature Date

Please check your preferred means of communication (you may check more than one):

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You may send me an email at: _____
- ☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

*** * ***

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) _____

Staff Person Initials _____