ABOUT YOU(THE PATIENT):

Today's Date: ______________

Mr. / Mrs. / Miss: ______________________ I prefer to be called: ______________
Birthdate: ______________ Age: _________ Social Security #: ______________
Home Address: ____
City/State: ______________________________ Zip: ______________
Home #: ______________ Work #: ______________ Cell #: ______________
Occupation: ______________ Employer: ______________ Address: ______________
Spouse Name: ______________ Birthdate: __________ Social Security #: __________
Employer: ______________ Work #: ______________ Cell #: ______________

Person Responsible for Account: ______________________________
Billing Address: ______________________ City/State: __________ Zip: ______
Employer: ____________________ Work #: ______________ Cell #: __________
Relationship to you: ____________________ Social Security #: ______________
Referred By: ____

Dental Insurance: ____
Primary Insurance Company Name: ____________________ Group #: __________
Secondary Insurance Company Name: __________________ Group #: __________
In case of an emergency, please contact: ______________ **Phone #:** __________

MEDICAL HISTORY:

Physician: ______________________________ Phone #: ______________
Your current health is: Good___________ Fair___________ Poor___________
Are you currently under the care of a physician? No __________ Yes __________
If yes, please explain: ____
Do you have any existing illness? No________________ Yes________________
If yes, please explain: ____
Have you been hospitalized in the past two years? No__________ Yes__________
If yes, please explain: ____
******DO YOU BLEED EXCESSIVELY WHEN CUT? _______YES________NO**
Do you use tobacco products? No____ Yes _____ If yes, what?________________
Are you taking any medications, pills or drugs? No_____ Yes _____ If yes, please list:

____

____

Do you have or have you had any of the following?

Y	N	High Blood Pressure	Y	N	Liver Disease
Y	N	Blood Disease	Y	N	Kidney Disease
Y	N	Rheumatic Fever	Y	N	Hepatitis
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Asthma
Y	N	Diabetes	Y	N	Tuberculosis
Y	N	Stroke	Y	N	Epilepsy
Y	N	Arthritis/ Rheumatoid Arthritis	Y	N	Tumor History
Y	N	Radiation/ Chemo Therapy	Y	N	Heart Disease
Y	N	Cancer____________	Y	N	Are You Pregnant?
Y	N	Acid Reflux/GERD	Y	N	Hearing Problems
Y	N	Pacemaker/ Artificial Heart Valve	Y	N	Joint Replacement
Y	N	Systemic Pulmonary Shunt	Y	N	HIV/ AIDS/ VD

ALLERGY TO: Penicillin _____ Other Antibiotics __________ Other ________

Have you ever been treated for osteoporosis or cancer with *bisphosphonates*????? Y N

Have you ever taken any of the following medications?:

Actonel (risedronate)	**Aredia (pamidronate)**	**Bonefos (clodronate)**
Boniva (ibandronate)	**Didronel (etidronate)**	**Fosamax (alendronate)**
Ostac (clodronate)	**Skelid (tiludronate)**	**Zometa (zoledronic acid)**

DENTAL HISTORY:

Do you have any present dental complaints? If yes, please explain: ____________________

____

When was your last full mouth X-ray taken? ______________________________

When was your last cleaning? ____________________ Where? ________________

Have you ever been instructed in the prevention of decay? ____________________

Have you ever been instructed in the caring for your gums? ___________________

REMARKS:

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.**

Signature: ____________________________________ **Date:** ______________________

Signature of Guardian (if patient is a minor): ________________________________

PAYMENT ARRANGEMENT:

I will be paying by:

- **CHECK**
- **CASH**
- **CREDIT CARD**
- **INSURANCE** –Insurance assignment with benefits payable to Dr. Joseph R. Anderson and patient's understanding that their portion is due at the time services are rendered. Patient will be responsible for any benefits unpaid by the insurance company.

Signature: ______________________ **Drivers License #:** ______________ **Date:** ______

Signature of Legal Guardian (if patient is a minor):

____

Patient's Name: ______________________ **Date:** ________________

TMJ (Temporomandibular Joint) Health Questionnaire

(Please circle yes or no below on every question)

The temporomandibular joint is the articulation between the mandible and the two temporal bones of the skull. This joint is most commonly used when opening and closing your mouth. Read over the below questions and let us know if you have suffered from any of these problems?

PAIN SYMPTONS:

Question		
Do you get tension headaches?	Y	N
Do you get migraine headaches?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N
Do you have trouble sleeping soundly?	Y	N
Have your teeth been sore upon awakening?	Y	N
Does your jaw ache when you chew?	Y	N
Do you have ear pain?	Y	N
Does your jaw ache when you open wide?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N
Do you get headaches in the right or left temple areas?	Y	N
Do you get headaches in the back of your head?	Y	N
Do you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken from sleep?	Y	N

When are your symptoms the worse?____________

Does anything make you feel better?____________

Question		
Have your wisdom teeth been extracted?	Y	N

What medications, if any are you taking?__________

____

How often do you take medication for relief of pain?
a.) never b.) weekly to monthly c.) weekly d.) daily

TRAUMA OR ACCIDENTS:

Question		
Have you ever had a severe blow to the head or jaw?	Y	N
Any whiplash neck injuries?	Y	N
Have you ever been involved in any serious accidents, such as a car accident? Details:________________	Y	N

JAW JOINT SYMPTOMS:

Question		
Does your jaw feel tired after a big meal?	Y	N
Are there any foods you avoid eating?	Y	N
Do you ever get dizzy?	Y	N
Do you ever feel faint?	Y	N
Do you feel nauseated (sick)?	Y	N
Is there a family history of jaw joint (TMJ)problems or headaches?	Y	N
Do you feel or hear clicking, popping or cracking noise from either jaw joint?	Y	N
Has your jaw ever locked where you were unable to open or close?	Y	N
Do you have difficulty opening wide or yawning?	Y	N
Have you ever had pain in either jaw joint?	Y	N

EAR AND EYE SYMPTOMS:

Question		
Do you have itchiness or stuffiness in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N
Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you hear grating noises in ears? (like sand particles rubbing)	Y	N
Do you wear glasses or contact?	Y	N
Does your eyesight blur?	Y	N

BREATHING:

Question		
Do you have allergies?	Y	N
Do you have sinus problems?	Y	N
Do you snore at night?	Y	N
Is your nose stuffed when you don't have a cold?	Y	N