Cris Simmons DDS

YOUR JAW PAIN & TMJ EXPERT

PATIENT INFORMATION

Patient: Name:	Preferred Name:_____	
	Marital Status: □ Single □ Married □ Divorced □ Partnered	
Social Security No:	Birth Date:	Occupation:
Home Address:	City, State:	ZIP:
Home Phone:	Cell Phone:	Work Phone:
Email Address:	What is the best way to reach you?	
Employer:	Employer Address:	
Spouse / Parent / Partner (circle):	Same Address? □ Yes □ No (if no please fill in below)	
Address:	Phone:	
Whom may we thank for referring you?	Have you seen our website/blog? □ Yes □ No	

OTHER CARE PROVIDERS

Physician:	Office Phone:
Chiropractor:	Office Phone:
Massage Therapist:	Office Phone
Physical Therapist:	Office Phone:
Dentist:	Office Phone
Other:	Office Phone:

EMERGENCY CONTACT

Name:	Phone:	Relationship:

FINANCIAL RESPONSIBILITY

I understand that payment is due in full at the time services are rendered. I understand that I am solely responsible for payment and give my permission for approved services rendered.

Signature_____ Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand my personal information will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may or may not be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my healthcare/dental services.
- Conduct normal healthcare/dental operations such as quality assessment and improvement activities.

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/dental operations and that you are not required to agree to my requested restriction, but if you do agree that you are bound to abide by such restrictions.

The above information is true to the best of my knowledge. I authorize Cris Simmons, DDS or insurance company to release any information required to process my claims.

Signature_____ Date_____

Relationship to Patient _____

Craniofacial Pain Chief Complaint Index

NAME_____ **DATE**_____

Please indicate your main complaints in order of their current importance

1)_____

2)_____

3)_____

Please place an "X" next to the symptoms you regularly or occasionally have

Please indicate right or left where applicable

	Current Symptom	Right	Left
Ear problems			
buzzing/ringing sounds (tinnitus)	____	____	____
diminished hearing	____	____	____
ear pain without infection	____	____	____
clogged/stuffy/itchy ears	____	____	____
Balance problems (vertigo)	____		
Head pain, headaches, and facial pain			
forehead	____	____	____
temples	____	____	____
migraine type headaches	____	____	____
cluster headaches	____	____	____
sinus headaches	____	____	____
occipital (back of head) headaches	____	____	____
hair/scalp painful to touch	____	____	____
Eye pain and Problems			
eye pain: above behind and below	____	____	____
bloodshot eyes	____	____	____
blurring of vision	____	____	____
bulging of appearance	____	____	____
pressure behind eyes	____	____	____
light sensitivity	____	____	____
watery eyes	____	____	____
drooping of the eye lids	____	____	____
Neck and shoulder problems			
Lack of mobility/reduced range of motion	____	____	____
stiffness	____		
neck pain	____	____	____
tired, sore neck muscles	____	____	____
shoulder aches	____	____	____
upper and lower back pain	____	____	____
arm and finger tingling, numbness, or pain	____	____	____

	Current Symptom	Right	Left
Jaw and jaw joint problems			
pain in jaw joints	____	____	____
clicking, popping jaw joints	____	____	____
grating sounds	____	____	____
jaw locking open/closed	____	____	____
pain in cheek muscles	____	____	____
uncontrollable jaw/tongue movements	____		
Mouth, face, cheek, and chin problem			
discomfort	____	____	____
inability to open smoothly/evenly	____	____	____
jaw deviate to one side on opening	____	____	____
inability to find bite	____		
limited opening	____		
Teeth and gum problems			
clenching	____		
grinding	____		
looseness/soreness of back teeth	____		
tooth pain	____		
Throat problems			
swallowing difficulties	____		
tightness of throat	____		
sore throat without infection	____		
voice fluctuations	____		
laryngitis	____		
frequent coughing or constant clearing of throat	____		
feeling of foreign object in throat	____		
tongue pain	____		
salivation	____		
pain in hard palate (roof of mouth)	____		

Are theses symptoms related to an accident (automobile, personal injury, L&I, ect) Yes / No

Date(s) of accident _____

HEALTH HISTORY QUESTIONNAIRE

Name_____ Date_____

Date of last medical exam_____ Date of last eye exam_____

Do you require antibiotic premedication prior to dental treatment? □Yes □No

PLEASE CHECK IF YOU HAVE OR HAVE HAD THE FOLLOWING:

□ Rheumatic Fever	□ Significant Weight Change	□ Osteoporosis	□ Psychiatric Disorder
□ Mitral Valve Prolapse	□ Fingernails Break Easily	□ Bothered by Cold Temperatures	□ Asthma
□ Artificial Heart Valve	□ Anemia	□ Angina/Chest Pain	□ Steroid Therapy
□ AIDS/HIV	□ Chronic Bronchitis	□ Congestive Heart Failure	□ Recent Surgery
□ Allergies	□ Glaucoma	□ Heart Disease	□ Arthritis
□ Artificial Joints	□ Stroke	□ High Blood Pressure	□ Drug/Alcohol Abuse
□ Latex Allergy	□ Regurgitation	□ Neurological Disorders	□ Epilepsy
□ Heart Murmur	□ Thyroid Problems	□ Sinus Trouble	□ Psychological Problems
□ Kidney Disease	□ Fainting/Dizzy Spells	□ Tuberculosis	□ Snoring/Sleep Apnea
□ Diabetes	□ Ulcers	□ Herpes	□ Liver Disease
□ Hepatitis, Type_____	□ Easy Bleeding	□ Hemophilia	□ Other_____

PLEASE LIST YOUR PRESCRIBED,OVER-THE-COUNTER, NATUROPATHIC, OR HOMEOPATHIC MEDICATIONS:

ALLERGIES TO MEDICATIONS:

HABITS:

Do you use recreational drugs?	□Yes	□No	
Caffeine intake?	□Yes	□No	Cups/cans per day?_____
Do you drink alcohol?	□Yes	□No	How often?_____
Do you use tobacco?	□Yes	□No	How often?_____
			□Cigarettes □Chew □Pipe □Cigars

WOMEN ONLY:

Are you pregnant or potentially pregnant?	□Yes	□No
Are you breastfeeding?	□Yes	□No
Do you have irregular menstrual cycles?	□Yes	□No
Have you been diagnosed with PMS?	□Yes	□No
Have you had a hysterectomy?	□Yes	□No
Are you menopausal?	□Yes	□No

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Simmons or any members of his team responsible for errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

DENTAL HISTORY QUESTIONNAIRE

Name_____ Date_____

Date of last dental exam_____ Date of last cleaning_____

Do you require antibiotic premedication prior to dental treatment? □ *Yes* □ *No*

What are your main dental concerns?

How do you care for your teeth and gums?

Please check yes or no.

Are you presently in pain?	Yes	No	Are you aware of clenching your teeth during the day?	Yes	No
Have you experienced any unfavorable reaction to dentistry?	Yes	No	Do you have difficulty opening your mouth widely?	Yes	No
Have you lost any teeth?	Yes	No	Do you feel you will eventually wear dentures?	Yes	No
Do you have any growth or swelling in your mouth?	Yes	No	Do any members of your family wear dentures?	Yes	No
Do your gums bleed when you brush or floss your teeth?	Yes	No	Do you bite or chew on pencils, pens, etc.?	Yes	No
Do you avoid brushing any part of your mouth?	Yes	No	Do you slouch while watching TV?	Yes	No
Have you ever had a bad reaction to dental anesthetics?	Yes	No	Do you work on a computer for long periods of time?	Yes	No
Is any part of your mouth sensitive to temperature?	Yes	No	Do you do any heavy lifting?	Yes	No
Is any part of your mouth sensitive to food or drink?	Yes	No	Do you lean your chin on your hand?	Yes	No
Do you ever have a burning sensation in your mouth?	Yes	No	Do you bite your fingernails?	Yes	No
Does food get caught between your teeth?	Yes	No	Have you been told you grind your teeth during sleep?	Yes	No
Do you experience an unpleasant taste or odor in your mouth?	Yes	No	Do you chew on your cheeks or lips?	Yes	No
Are you happy with the appearance of your teeth?	Yes	No	Do you smoke a pipe?	Yes	No
Have you ever been told you have gum disease?	Yes	No	Do you carry a heavy shoulder bag?	Yes	No
Have you ever had a root canal?	Yes	No	Do you cradle the phone on your shoulder?	Yes	No
Have you ever had orthodontic treatment?	Yes	No	Do you feel your teeth hit in the front first?	Yes	No
Have you ever had an oral surgery procedure not related to teeth?	Yes	No	Do you have any clicking or popping in your jaw ?	Yes	No
Do you chew gum or use mints, cough drops, hard candy?	Yes	No	Have you been told you have oral cancer?	Yes	No
Do you wear any dental appliances?	Yes	No			