Cris Simmons DDS

YOUR JAW PAIN & TMJ EXPERT

PATIENT/PARENT INFORMATION

Patient Name:	Preferred Name:	
Date of Birth:	Preferred Contact Method:	
Address:	City/State:	Zip:
Mom's Name:	Cell Phone:	Work Phone:
Dad's Name:	Cell Phone:	Work Phone:
Parents Above are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered	Home Phone:	
Responsible Party:	Email:	
Address:	City/State:	Zip:
Whom may we thank for referring you?	Have you seen our website/blog? ☐ Yes ☐ No	
Do you belong to any parenting groups?		

OTHER CARE PROVIDERS

Physician:	Office Phone:
Dentist:	Office Phone
Other:	Office Phone:
Other:	Office Phone:

EMERGENCY CONTACT

Name:	Phone:	Relation:

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 _______________________________________

CHILD HEALTH HISTORY QUESTIONNAIRE

Name____ Date____

Date of last medical exam____________________________ Date of last dental exam____________________________

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

PLEASE CHECK IF YOU HAVE OR HAVE HAD THE FOLLOWING:

- ☐ Latex Allergy
- ☐ Fainting/seizures
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Abnormal Bleeding
- ☐ Hemophilia
- ☐ Anemia
- ☐ Kidney Disease
- ☐ Ear Infections
- ☐ Liver Disease
- ☐ Congenital Hear Defect
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Respiratory Problems
- ☐ Thyroid Problem
- ☐ Leukemia
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Allergies
- ☐ Tuberculosis
- ☐ Hearing Impairment
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach Ulcers
- ☐ Hay Fever
- ☐ Special Needs
- ☐ Asthma
- ☐ ADHD
- ☐ Psychiatric Disorder
- ☐ Anxiety
- ☐ Headache
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Drug/Alcohol Abuse
- ☐ Other_______________

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

ALLERGIES TO MEDICATIONS:

HABITS:

Thumb or digit sucking	▫Yes	▫No
Pacifier use	▫Yes	▫No
Mouth Breathing day or night	▫Yes	▫No
Nail Biting	▫Yes	▫No

DENTAL HISTORY

Does your child brush daily? ▫Yes ▫No Times____________ ▫Alone ▫Assisted
Does your child floss daily? ▫Yes ▫No Times____________ ▫Alone ▫Assisted
Has your child had any injuries to the mouth/teeth/face? ▫Yes ▫No
Has your child experienced jaw popping or pain? ▫Yes ▫No
Has your child experienced difficulty opening/closing/chewing ▫Yes ▫No
Does your child clench or grind teeth? ▫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____

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 ____