TMD REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient _____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer_____

Employer Address_____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Subscriber # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate _____ SS# _____

Relationship to Patient _____

Secondary Insurance Co. _____

Subscriber # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and I assign directly to Dr. Irina Deresh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home Phone _____ Work/Cell Phone _____

4 HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth?	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw Pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken filings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

How often to you floss?_____

How often do you brush?_____

TURN PAGE OVER

5 HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐Yes	☐No	Emphysema	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Alzheimers	☐Yes	☐No	Epilepsy	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting or dizziness	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Glaucoma	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Headaches	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Problems	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Back Problems	☐Yes	☐No	Hepatitis (Type _____)	☐Yes	☐No	Skin Rash	☐Yes	☐No
Bleeding abnormally, with extraction or surgery	☐Yes	☐No	Herpes	☐Yes	☐No	Special Diet	☐Yes	☐No
			High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Disease	☐Yes	☐No	HIV Positive	☐Yes	☐No	Swelling of Feet or Ankles	☐Yes	☐No
Cancer	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Jaw Pain	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No			
Cough, persistent or bloody	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Ulcer	☐Yes	☐No
Diabetes	☐Yes	☐No	Pacemaker	☐Yes	☐No	Venereal Disease	☐Yes	☐No

WOMEN: Are you: **Pregnant?** ☐Yes, _____ Months ☐No **Nursing?** ☐Yes ☐No **Taking birth control pills?** ☐Yes ☐No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐Aspirin ☐Penicillin

☐Barbiturates (Sleeping pills) ☐Sulfa

☐Codeine ☐Other _____

☐Iodine _____

☐Latex _____

☐Local Anesthetic _____

X _____

SIGNATURE OF PATIENT OR PARENT OF MINOR

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last appointment? ☐Yes ☐No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last appointment? ☐Yes ☐No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Irina Deresh, DMD
General and Cosmetic Dentistry

Temporomandibular Disorder History Form

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems	Left	Right	
Joint clicking or popping	☐Yes ☐No	☐Yes ☐No	Comments _____
Grating noises	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw locks open	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw locks closed	☐Yes ☐No	☐Yes ☐No	Comments _____
Limited jaw opening	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw does not open smoothly	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of jaw joints	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of face muscles	☐Yes ☐No	☐Yes ☐No	Comments _____

Teeth Problems			
Teeth grinding	☐Yes ☐No	☐Yes ☐No	Comments _____
Teeth clenching	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of one or more teeth	☐Yes ☐No	☐Yes ☐No	Comments _____
Looseness of one or more teeth	☐Yes ☐No	☐Yes ☐No	Comments _____

Head and Facial Pain	Left	Right	(least) Degree of Pain (most)
Migraine type headache	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Cluster headaches	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sinus headaches	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Headaches in back of head	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Hair and/or scalp painful to touch	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Ear or Balance Problems		
Pain in ear	☐Yes ☐No	Comments _____
Ringing or buzzing	☐Yes ☐No	Comments _____
Clogged or stuffy ears	☐Yes ☐No	Comments _____
Diminished hearing	☐Yes ☐No	Comments _____
Dizziness or vertigo	☐Yes ☐No	Comments _____
Poor sense of balance	☐Yes ☐No	Comments _____

Throat Problems

Swallowing difficulty	☐Yes ☐No	Comments	_____
Throat tightness	☐Yes ☐No	Comments	_____
Throat soreness	☐Yes ☐No	Comments	_____
Laryngitis	☐Yes ☐No	Comments	_____
Voice fluctuations	☐Yes ☐No	Comments	_____
Throat congestion	☐Yes ☐No	Comments	_____
Frequent cough	☐Yes ☐No	Comments	_____
Frequent throat clearing	☐Yes ☐No	Comments	_____
Excessive salivation	☐Yes ☐No	Comments	_____
Tongue pain	☐Yes ☐No	Comments	_____
Pain in roof of mouth	☐Yes ☐No	Comments	_____

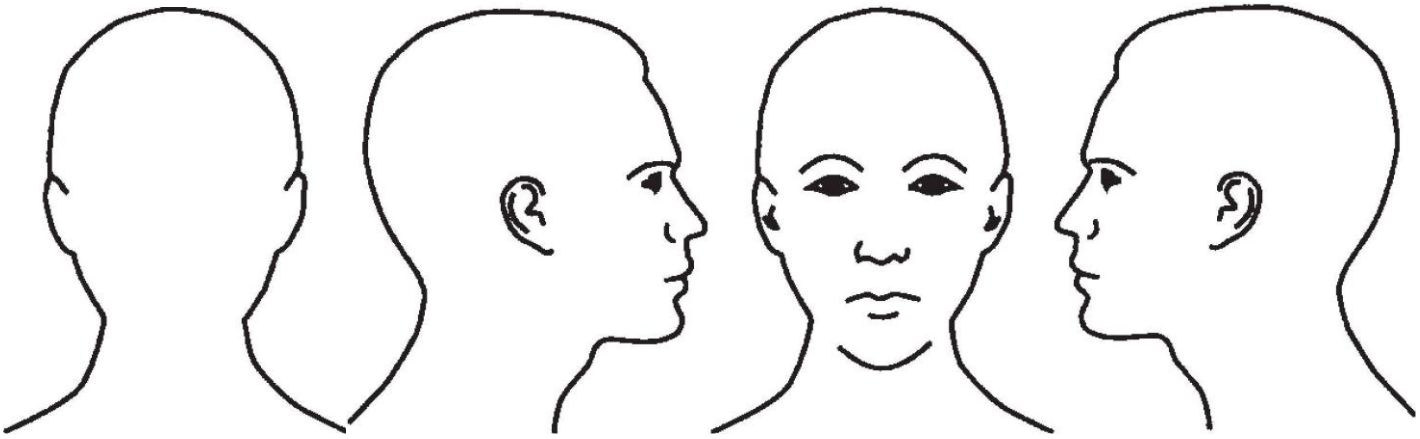
Neck and/or Shoulder Pain

Neck/shoulder/back pain	☐Yes ☐No	Comments	_____
Neck/shoulder/back reduced mobility	☐Yes ☐No	Comments	_____
Frequent neck muscle fatigue	☐Yes ☐No	Comments	_____
Arm or finger tingling, numbness, pain	☐Yes ☐No	Comments	_____

Eye Problems

Pain around or behind eyes	☐Yes ☐No	Comments	_____
Bloodshot eyes	☐Yes ☐No	Comments	_____
Blurred vision	☐Yes ☐No	Comments	_____
Pressure behind eyes	☐Yes ☐No	Comments	_____
Light sensitivity	☐Yes ☐No	Comments	_____
Watering of eyes	☐Yes ☐No	Comments	_____
Drooping of eyelids	☐Yes ☐No	Comments	_____

On the figures below, mark an X where you have pain. Circle the X where the pain is most severe.



PATIENT HEALTH INFORMATION

Do you have any recent or childhood history of trauma to the head or face (such as falls, auto accident, blows to the head or face, sports injury)? If yes, please describe: _____

Do you have a frequent activity that causes you to hold your head or neck in an imbalanced position (such as playing instrument, keyboarding, holding phone, etc)? If yes, please describe: _____

Have you been treated for a TMD problem before? If so, when?_____ By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____

Do you think the treatment was successful? _____

What would you like your treatment here to achieve? _____

UPDATES

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

MEDICAL INSURANCE FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality materials we use, and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates.

Your insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need.

We accept the following forms of payment: Cash, Check, Credit/Debit cards, Apple Pay as well as CareCredit. In addition, we offer patient financing programs such as Lending Club and Care Credit, offering No Interest Plans and Extended Payment Plans for treatment.

Payment for services is due at the time services are rendered unless prior arrangements have been made.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to speak with us or contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact us at any time to discuss any concerns you may have.

Thank you for understanding our Financial Policy.

RESERVATION POLICY

Due to the extensive amount of time our doctor and staff devote to preparing and reserving uninterrupted time for reservations, $75 will be collected for any appointment cancelled without at least a 24-hour notice. This fee will be charged to the credit card on file.

RESCHEDULING / CHANGE IN SCHEDULE POLICY

Our practice is dedicated to quality care and exceptional service. Our doctor and staff spend extensive amount of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50.00 will be charged for every hour of allotted time cancelled to your credit card on file.

I have read and agree to the Financial Policy and the Cancellation Policy of Irina Deresh DMD Practice. I agree to a credit card on file that may be charged for violation of these policies or upon my approval for services rendered.

Full Name: _____ Signature of Patient: _____ Date: _____

Credit Card Number: _____ Expiration Date: _____ CVV Code: _____