WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to serve you properly, we will need the following information. (Please print.) All information will be strictly confidential.

Patient's name		Birthdate	Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence address	City State	Zip	Home phone
If child, parent's name or guardian's name			
Name of employer	Address		Business phone
Social security number	Driver's license		Occupation
Do you have medical insurance? ☐ Yes ☐ No	If no, how do you intend to pay? ☐ Check ☐ Cash ☐ Credit card		Insurance company name and address
Subscriber name	Policy no.	Certificate no.	Is it through your employer? ☐ Yes ☐ No
Name of spouse	Social security number		Business phone
Is there secondary insurance, spouse second carrier, etc.? ☐ Yes ☐ No		Name and address of spouse employer	
Secondary insurance name and address		Policy no.	Certificate no.
Medicare no.		Medicaid no.	
Workmen's compensation		Name of company	
Address of company	Company phone		Treatment authorized by
Person financially responsible for this account		Address	Relationship to Patient
Person to contact in emergency	Relationship to Patient		Phone (W) Phone (H)
Whom may we thank for referring you?		Address	

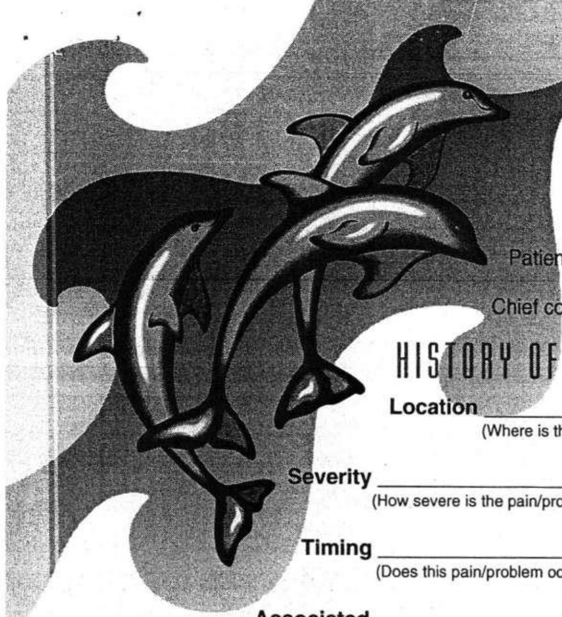
Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Patient, Parent, or Guardian Signature ______________________________ Date ______________



WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability.

Patient name ______________________ Age __________ Date __________

Chief complaint ____

HISTORY OF PRESENT ILLNESS

Location ______________________
(Where is the pain/problem?)

Duration ______________________
(How long have you had this pain/problem, or when did it start?)

Severity ______________________
(How severe is the pain/problem on a scale of 1-5 [5 being the most severe])

Context ______________________
(Where were you at the onset of this pain/problem?)

Timing ______________________
(Does this pain/problem occur at a specific time?)

Quality ______________________
(Example: normal versus abnormal color, activity, etc.)

Associated Signs/ Symptoms ______________________
(What other associated problems have you been having?)

Modifying Factors ______________________
(What makes the pain/problem worse or better? Have you had previous episodes?)

PATIENT MEDICAL HISTORY

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Condition		Condition		Condition		Condition	
Measles	☐ No ☐ Yes	Anemia	☐ No ☐ Yes	Blood or Plasma Transfusions	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes
Mumps	☐ No ☐ Yes	Bladder Infections	☐ No ☐ Yes	Back Trouble	☐ No ☐ Yes	Mitral Valve Prolapse	☐ No ☐ Yes
Chickenpox	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	High or Low Blood Pressure	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Whooping Cough	☐ No ☐ Yes	Migraine Headaches	☐ No ☐ Yes	Hemorrhoids	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes
Scarlet Fever	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Ulcer	☐ No ☐ Yes
Diphtheria	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Hives or Eczema	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes
Smallpox	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	AIDS or HIV+	☐ No ☐ Yes	Thyroid Disease	☐ No ☐ Yes
Pneumonia	☐ No ☐ Yes	Polio	☐ No ☐ Yes	Infectious Mono	☐ No ☐ Yes	Bleeding Tendency	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes	Any Other Disease (please list) ______	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Hernia	☐ No ☐ Yes	Usual Weight	______		
Arthritis	☐ No ☐ Yes						

Previous Hospitalizations/Surgeries/Serious Illnesses When Hospital, city, state

____

____

____

____

Medications: Include strength and daily dose ______________________ ☐ None

Include non-prescription: Ex; Aspirin, Vitamins, Fen-Phen, Herbals, L-Triptophan ______________________ ☐ None

____

____

____

____

Habits

Smoking: Type and amount per day. ______________________ ☐ None

If former smoker: Type, amount and date quit. ______________________ ☐ None

Alcohol: Type and amount per day. ______________________ ☐ None

If former user: Type, amount and date quit. ______________________ ☐ None

Caffeine use: Type and amount per day. Ex; coffee, tea, soda drinks ______________________ ☐ None

Herbal teas: Type and amount ______________________ ☐ None

Recreation drugs: ______________________ ☐ None

FORM 103875 R/04/99 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

DIET

Are you dieting?

Do you eat three meals a day?

Are they at regular hours?

Do you eat breakfast? How often?

Meal consists of:

Do you eat lunch? How often?

Meal consists of:

Do you eat dinner? How often?

Meal consists of:

Do you snack? How often?

Snacks consists of:

SLEEP PATTERN

When do you go to bed: When do you awaken?

Do you have trouble falling asleep?

Do you awaken during the night? How often?

Do you have difficulty in going back to sleep?

Do you take naps? How often? When? How long?

FAMILY HISTORY

Family History	IF LIVING	Health			IF DECEASED		Any blood relatives who have or have had any of the listed conditions							
	Age	Good	Fair	Poor	Death Age	Death Cause		✓Yes	No	Relationship		✓Yes	No	Relationship
Father							Asthma				Hay Fever			
Mother							Arthritis				Kidney Disease			
Brothers (Circle)							Allergies				Leukemia			
Sisters Sex)							Anemia				Migraine			
1. M F							Alcoholism				Nervous Break'n			
2. M F							Bleeding Tend.				Obesity			
3. M F							Cancer				Rheumatism			
4. M F							Colitis				Rheumatic Fever			
5. M F							Congenital Heart				Stroke			
Husband ☐							Diabetes				Suicide			
Wife ☐							Epilepsy				Stomach Ulcers			
Sons (Circle							Goiter				Tuberculosis			
Daughters Sex)							High Bl. Press.				Thyroid Disease			
1. M F							Heart Disease				Mental Illness			
2. M F							Glaucoma							
3. M F							Gout							
4. M F							Drug Problem							
5. M F														

SOCIAL/OCCUPATION HISTORY

Place of Birth:

Highest level of school:

Occupation:

Previous occupations:

Martial status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Hobbies/Recreation:

Exercise:

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

REVIEW OF SYSTEMS

Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS
- Good general health lately ☐ No ☐ Yes
- Recent weight change ☐ No ☐ Yes
- Fever ☐ No ☐ Yes
- Fatigue ☐ No ☐ Yes
- Headaches ☐ No ☐ Yes

EYES
- Eye disease or injury ☐ No ☐ Yes
- Wear glasses/contact lenses ☐ No ☐ Yes
- Blurred or double vision ☐ No ☐ Yes

EARS/NOSE/MOUTH/THROAT
- Hearing loss or ringing ☐ No ☐ Yes
- Earaches or drainage ☐ No ☐ Yes
- Chronic sinus problems or rhinitis ☐ No ☐ Yes
- Nose bleeds ☐ No ☐ Yes
- Mouth sores ☐ No ☐ Yes
- Bleeding gums ☐ No ☐ Yes
- Bad breath or bad taste ☐ No ☐ Yes
- Sore throat or voice change ☐ No ☐ Yes
- Swollen glands in neck ☐ No ☐ Yes

CARDIOVASCULAR
- Heart trouble ☐ No ☐ Yes
- Chest pain or angina pectoris ☐ No ☐ Yes
- Palpitation ☐ No ☐ Yes
- Shortness of breath with walking or lying flat ☐ No ☐ Yes
- Swelling of feet, ankles or hands ☐ No ☐ Yes

RESPIRATORY
- Chronic or frequent coughs ☐ No ☐ Yes
- Spitting up blood ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Wheezing ☐ No ☐ Yes

GASTROINTESTINAL
- Loss of appetite ☐ No ☐ Yes
- Change in bowel movements ☐ No ☐ Yes
- Nausea or vomiting ☐ No ☐ Yes
- Frequent diarrhea ☐ No ☐ Yes
- Painful bowel movements or constipation ☐ No ☐ Yes
- Rectal bleeding or blood in stool ☐ No ☐ Yes
- Abdominal pain ☐ No ☐ Yes

GENITOURINARY
- Frequent urination ☐ No ☐ Yes
- Burning or painful urination ☐ No ☐ Yes
- Blood in urine ☐ No ☐ Yes
- Change in force of strain when urinating ☐ No ☐ Yes
- Incontinence or dribbling ☐ No ☐ Yes
- Kidney stones ☐ No ☐ Yes
- Female - yeast infections ☐ No ☐ Yes

MUSCULOSKELETAL
- Joint pain ☐ No ☐ Yes
- Joint stiffness or swelling ☐ No ☐ Yes
- Weakness of muscles or joints ☐ No ☐ Yes
- Muscle pain or cramps ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Cold extremities ☐ No ☐ Yes
- Difficulty in walking ☐ No ☐ Yes

INTEGUMENTARY (skin, breast)
- Rash or itching ☐ No ☐ Yes
- Change in skin color ☐ No ☐ Yes
- Change in hair or nails ☐ No ☐ Yes
- Varicose veins ☐ No ☐ Yes
- Breast pain ☐ No ☐ Yes
- Breast lump ☐ No ☐ Yes
- Breast discharge ☐ No ☐ Yes

NEUROLOGICAL
- Frequent or recurring headaches ☐ No ☐ Yes
- Light headed or dizzy ☐ No ☐ Yes
- Convulsions or seizures ☐ No ☐ Yes
- Numbness or tingling sensations ☐ No ☐ Yes
- Tremors ☐ No ☐ Yes
- Paralysis ☐ No ☐ Yes
- Head injury ☐ No ☐ Yes

PSYCHIATRIC
- Memory loss or confusion ☐ No ☐ Yes
- Nervousness ☐ No ☐ Yes
- Depression ☐ No ☐ Yes
- Insomnia ☐ No ☐ Yes

ENDOCRINE
- Glandular or hormone problem ☐ No ☐ Yes
- Excessive thirst or urination ☐ No ☐ Yes
- Heat or cold intolerance ☐ No ☐ Yes
- Skin becoming drier ☐ No ☐ Yes
- Change in hat or glove size ☐ No ☐ Yes

HEMATOLOGIC/LYMPHATIC
- Slow to heal after cuts ☐ No ☐ Yes
- Bleeding or bruising tendency ☐ No ☐ Yes
- Anemia ☐ No ☐ Yes
- Phlebitis ☐ No ☐ Yes
- Past transfusion ☐ No ☐ Yes
- Enlarged glands ☐ No ☐ Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics ☐ No ☐ Yes
- Morphine, Demerol, or other narcotics ☐ No ☐ Yes
- Novocain or other anesthetics ☐ No ☐ Yes
- Aspirin or other pain remedies ☐ No ☐ Yes
- Tetanus antitoxin or other serums ☐ No ☐ Yes
- Iodine, methiolate or other antiseptics ☐ No ☐ Yes

Other drugs/medications: ____________

Known food allergies ____________

Environmental allergies: ____________

Person to Notify in Emergency	Daytime Phone Number	Relationship
Last Physical Examination Date	By Doctor	Address/Phone Number
Family or Referring Doctor	Phone Number	May I Contact Either of These Doctors For Your Past Health Records? Yes ☐ No ☐

AUTHORIZATION & RELEASE
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X ____________ ____________

Signature of patient (or parent if minor) Date

Doctor's Review: ____________

Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Insulin/other diabetes drugs	☐	☐
Blood pressure medication	☐	☐	Recreational drugs	☐	☐
Thyroid medicine	☐	☐	Digitalis/other heart medications	☐	☐
Cortisone/steriods	☐	☐	Nitroglycerin	☐	☐
Antihistamines/allergy drugs/cold remedies	☐	☐	Aspirin	☐	☐
			Other medication ______		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. ______ 4. ______

2. ______ 5. ______

3. ______ 6. ______

PHYSICIANS AND DENTISTS: Please Include Address: ______

Family Physician: ______

Internal Medicine: ______

Medical Oncology: ______

Radiation Oncology ______

ENT (Otolaryngology) ______

Other ______

Family Dentist: ______

Periodontist: ______

Oral Surgeon: ______

Prosthodontist: ______

Other: ______

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

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Ortho treatments (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaw	☐	☐	Shifting of teeth	☐	☐
Difficulty opening or closing jaw	☐	☐	Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO	How Often?
Toothbrush	☐	☐	______
Dental floss	☐	☐	______
Fluoride rinse	☐	☐	______
Mouth rinse	☐	☐	______
Waterpik	☐	☐	______
Proxy brush	☐	☐	______
Other	☐	☐	______

Brush is: ☐ Soft ☐ Med. ☐ Hard ☐ Electric

Toothpaste used: ______

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian ______ Date ______

THE BETHESDA
TEMPOROMANDIBULAR JOINTAND IMPLANT CENTER

FINANCIAL POLICY

Because medical and dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role or force us to compromise the quality of care to our patients.

When your office visit is completed, the receptionist will provide you with a super bill to submit to your insurance company so that you can be reimbursed. A dental claim will be submitted to your dental insurance company for reimbursement as well.

We will answer any questions your insurance company may raise about diagnosis or treatment in an appropriate, timely manner, but it is important to understand that the legal contract is between you and your insurance company—we are not part of the relationship. We are unable to "force" an insurance company to fulfill its obligations to you. Please contact your insurance company to find out if a procedure will be covered under your particular policy.

Failure to continue treatment after lab work has been completed will result in a charge equal to ½ of the usual charge for the completed lab work.

We would appreciate your payment for services as you receive them. **Please note that all accounts with a balance after 30 days are subject to a finance charge of 1% per month.**

I understand that I am directly and personally responsible to BTMJFPTC for all bills and that this authorization is made solely for the additional protection of BTMJFPTC. I agree to be responsible for all expenses, including interest at 1% per month (12% per year), reasonable attorney fees and court costs incurred by BTMJFPTC in collection of monies due and owing by me. I also agree to waive the defense of the statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services are rendered.

Attention Medicare Patients: **We will no longer submit claims to Medicare due to the Opt Out contract. You will be expected to pay in full for all treatment at the time of service.**

Please keep your appointments! Contact the office if you need to reschedule your appointment so that others can use the time. **Failure to cancel your appointment without 24 hours notice will result in the usual charge.**

I have read, understand and accept the above financial policy. I acknowledge that I am ultimately responsible for the amounts due and owing under this agreement regardless of my representation or coverage.

Patient	Date	Witness

10215 Fernwood Road, Suite 601 · Bethesda, Maryland 20817 · Phone (301) 493-9500 · Fax: (301) 897-5571 · email: bethesdatmj@gmail.com