Referred by _____

_____

_____

TEMPOROMANDIBULAR JOINT/ FACIAL PAIN TREATMENT CENTER

Name _____ SSN _____ DOB _____ Marital Status _____

Address _____ City/State/ZIP _____ Phone _____

Patient Employed By _____ Occupation _____

Business Address _____ City _____ Phone _____

Name of Dentist _____ Address _____ City _____

Name of Physician _____ Address _____ City _____

Height _____ Weight _____ Date of Last Physical Exam _____

In Case of Emergency Contact _____ Phone _____

Answer the following questions Yes (Y), No (N), or Don't Know (DK)	**Y**	**N**	**DK**	
1. Are you presently under a physician's care?	☐	☐	☐	1.
2. Are you taking any medication at the present time?	☐	☐	☐	2.
3. Have you ever had any major operations?	☐	☐	☐	3.
4. Have you ever been seriously ill?	☐	☐	☐	4.
5. Has a doctor ever said that you have heart trouble?	☐	☐	☐	5.
6. Has a doctor ever said that your blood pressure was too low or too high?	☐	☐	☐	6.
7. Have you ever had Rheumatic Heart Disease?	☐	☐	☐	7.
8. Have you ever had anemia?	☐	☐	☐	8.
9. Have you or any member of your family ever had diabetes?	☐	☐	☐	9.
10. Have you ever received treatment for any type of endocrine or glandular condition?	☐	☐	☐	10.
11. Are you thirsty much of the time and do you drink a lot of liquids?	☐	☐	☐	11.
12. Do you suffer from headaches or of pain in the face?	☐	☐	☐	12.
13. Are you under tension?	☐	☐	☐	13.
14. Has a physician ever told you that you have epilepsy?	☐	☐	☐	14.
15. Have you ever had a nervous breakdown?	☐	☐	☐	15.
16. Do you suffer from frequent colds, sore throats, or sinusitis?	☐	☐	☐	16.
17. Do you breathe primarily through your mouth?	☐	☐	☐	17.
18. Do you suffer from stomach trouble?	☐	☐	☐	18.
19. Have you ever had yellow jaundice or hepatitis?	☐	☐	☐	19.
20. Have you ever had liver or gall bladder trouble?	☐	☐	☐	20
21. Do you have kidney trouble?	☐	☐	☐	21
22. Are you on any special kind of diet?	☐	☐	☐	22.

	Y	N	DK	
23. Are you sensitive or allergic to any particular medication (Aspirin, Penicillin, Novocain)?	☐	☐	☐	23.
24. Do you have an allergy?	☐	☐	☐	24.
25. Have you ever been treated for a skin disease?	☐	☐	☐	25.
26. Are your joints often painful or swollen -- do you have arthritis?	☐	☐	☐	26.
27. Have you gained or lost much weight recently?	☐	☐	☐	27.
28. Has your doctor ever told you that you have a tumor or cancer?	☐	☐	☐	28.
29. When was the last time you had *any* x-rays taken?	☐	☐	☐	29.
30. Are you pregnant now?	☐	☐	☐	30.

Answer the following Frequently (F), Never (N), or Sometimes (S)	F	N	S	
31. I suffer from headaches, abdominal pain, diarrhea, and/or muscle pain.	☐	☐	☐	31.
32. I often feel dry mouth, butterflies in my stomach, light-headed, and/or palpitations.	☐	☐	☐	32.
33. My sleep is often disturbed.	☐	☐	☐	33.
34. I feel myself less interested in my surroundings.	☐	☐	☐	34.
35. Of late, I find myself short-tempered.	☐	☐	☐	35.
36. I have lost or gained more than 10 pounds in the last six months.	☐	☐	☐	36.
37. I find myself smoking or drinking more than I used to.	☐	☐	☐	37.
38. Of late, I have difficulty getting the day started.	☐	☐	☐	38.
39. I find myself spending less time with my family.	☐	☐	☐	39.
40. I cannot leave my work at the office.	☐	☐	☐	40.
41. I am more sensitive to deadlines than I used to be.	☐	☐	☐	41.
42. Minor aches and pains bother me more than they used to.	☐	☐	☐	42.
43. I feel more and more isolated.	☐	☐	☐	43.
44. I find myself getting more and more fatigued.	☐	☐	☐	44.
45. Of late, my ability to concentrate is impaired.	☐	☐	☐	45.
46. I find that repetitive thoughts are interfering with my efficiency.	☐	☐	☐	46.
47. I would characterize myself as neat and meticulous.	☐	☐	☐	47.
48. I have difficulty refusing a task when asked.	☐	☐	☐	48.
49. I generally procrastinate.	☐	☐	☐	49.

Signature _____ 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

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