Patient Name:____
First MI Last

Date of Birth: ____ / _____/_________ How do you wish to be addresses (nickname): ______________________________

☐ Male ☐ Female

Whom may we thank for your referral? ____

What can we help you with? ____

____

Street Address:_____________________________ City: __________________ State:_____ Zip:_________

Home #:__________________ Work #: __________________ Cell#: ____________________

Email address:______________________________________ Social Security Number: ___________________

Emergency Contact:____ Phone: ___________________

Other family members in this practice:____

We are a fee for service office and require payment at the time of your visit.

Consent and Release of Information

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I authorize Dr. Chase Edwards, D.D.S., PC and his associates to release any information pertinent to my diag-nosis or treatment to any third party participating in my health care or insurance coverage.

I certify that the medical history and information is complete and accurate.

Patient Signature:____ Date: _______________

Legal Guardian (if not patient): ____ Date: _______________

TMJ & SLEEP SOLUTIONS

ADVANCED TECHNOLOGY • COMPASSIONATE CARE • TRUSTED EXPERIENCE

Social History: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other ____________________

Occupation: ____________________

- ☐ Nonsmoker (never smoked)
- ☐ Ex-smoker
- ☐ Current smoker - How many packs per day?

Alcohol consumption:

- ☐ Never
- ☐ Occasional
- ☐ Frequent

Family History: (Please list any significant, known medical problems)

Father: ____________________ Mother: ____________________

Siblings: ____________________

Your children: ____________________

Review of Symptoms: Past/Present

None					
☐	Constitutional:	☐ Weight loss/gain ☐ Insomnia (chronic)	☐ Chills/Night Sweats	☐ Poor appetite	☐ Chronic fatigue
☐	Eyes:	☐ Blurry vision	☐ Eye pain	☐ Eye discharge	
☐	ENT:	☐ Sore throat (chronic) ☐ Congestion	☐ Hoarseness ☐ Tinnitus	☐ Ear pain ☐ Sinus problems	☐ Hearing loss ☐ Vertigo
☐	Cardiovascular:	☐ Chest pain	☐ Palpitations	☐ Rapid heart rate (A-Fib, other)	
☐	Respiratory:	☐ Shortness of breath	☐ Lung disease	☐ Chronic cough	
☐	Gastrointestinal:	☐ Nausea (chronic)	☐ IBS/Gluten sensitive	☐ Frequent heartburn	☐ Trouble swallowing
☐	Skin:	☐ Skin condition	☐ Mole changes	☐ Skin cancer	
☐	Musculoskeletal:	☐ Joint pain ☐ Joint surgery	☐ Muscle aches ☐ Back/neck pain	☐ Frequent leg cramps	
☐	Psychiatric:	☐ Anxiety/Depression	☐ Alcohol or drug treatment	☐ Panic attacks	
☐	Endocrine:	☐ Heat/Cold intolerance ☐ Hormone problems	☐ Excess thirst ☐ Hypo/Hyperglycemia	☐ Excess sweating ☐ Thyroid disease	
☐	Neurological:	☐ Seizures ☐ Loss of balance	☐ Migraines ☐ Speech problems	☐ Numbness ☐ Stroke	☐ Dizziness/vertigo
☐	Hem/Lymphatic:	☐ Swollen lymph nodes	☐ Bleeding disorder	☐ Blood clots	
☐	Allergic/Immune:	☐ Allergic reactions ☐ Hepatitis	☐ Hay fever (chronic) ☐ HIV positive	☐ Frequent infections ☐ Herpes/cold sores	

Dental History:

Your most recent dentist: ____________________ Date of last visit: ____________

Have you had: (check all that apply)

☐ Orthodontics (braces) ☐ Implants ☐ Splint/nightguard ☐ Problems keeping mouth open ☐ Trouble chewing

Bite/Jaw Concerns:

☐ Mismatched bite ☐ Hard to relax jaw ☐ Uncomfortable bite ☐ Teeth broken or worn down ☐ Clenching/grinding

Other: ____________________

Medical History Questionnaire

Name: ______________________________ Date: ______________

Thank you for being complete and accurate. This information will remain confidential.

Medical History:
Current Physician: ______________________________ Phone: ______________

Your last visit to a doctor: ____________ Reason: ______________________________

List any medications/substances that have caused an allergic reaction: ☐ None

____

____

____

Past Medical History: ☐ None

- ☐ Acid reflux/GERD/ulcer
- ☐ Artificial joints (hip, knee)
- ☐ Asthma/lung breathing problems
- ☐ Radiation treatment
- ☐ Neuralgia(s)
- ☐ Sleep apnea/snoring
- ☐ Cancer/chemotherapy
- ☐ Diabetes
- ☐ Heart disease/arrhythmia
- ☐ Kidney problems
- ☐ Medical marijuana use
- ☐ Neck/back/spine pain condition
- ☐ Heart murmur/surgery
- ☐ Blood pressure (high or low)
- ☐ High cholesterol
- ☐ Difficulty sleeping
- ☐ Arthritis
- ☐ Osteoporosis (Fosamax, etc.)
- ☐ Headaches (chronic)
- ☐ Rheumatic fever
- ☐ Chronic pain condition
- ☐ Sinus problems
- ☐ Migraines

Medication/Supplements: (Attach separate sheet if needed) ☐ None

____

____

____

____

Past Surgical History: ☐ None

____

____

____

____

Trauma History: ☐ None

Have you ever been involved in an automobile accident or had other trauma (horses, recreational injury, bike, etc)?

____

____

____

Medical History Questionnaire (cont.)

Additional Information:

Use this space to provide an additional information which may be important to your health care.

____

____

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Signature of Reviewing Physician | Date

Signature of Patient/Parent/Guardian | Date