TMJ & Sleep Solutions
Mark J. Barnes, DDS

Patient Name_____ _____ _____
FIRST MI LAST

Date of Birth:_____/_____/_____ How do you wish to be addressed (Nickname)?_____

Whom may we thank for your referral?_____

What can we help you with?_____

Street Address:_____

City:_____State:_____Zip:_____

Home #_____Work #_____Cell #_____

Male [ ] Female [ ] Single [ ] Married [ ] Divorced [ ] Other [ ]_____

E-mail Address_____

Employer _____

Social Security Number: _____

Emergency Contact Name:_____Phone_____

Other family members in this practice:_____

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 understand that I am responsible for all charges for treatment to me regardless of insurance coverage. By my signature I affirm that the above medical/dental history and other information is true and correct and I realize that I may endanger my health if I have not answered truthfully. I authorize Dr. Barnes, D.D.S.,PC and/or his associates to release any information pertinent to my diagnosis 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_____

MEDICAL HISTORY QUESTIONNAIRE

Name _____ **Date** _____

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

Medical History:

Current Physician Name:_____Phone: _____

Your last visit to a doctor?_____Why? _____

LIST ANY MEDICATION/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:

Antibiotics	Iodine	Pain Medication
Penicillin	Latex	Plastic
Aspirin	Local anesthetics	**Other:**
Codeine	Metal/Jewelry	

Medical Conditions: (Please Circle those that apply)

Acid Reflux/GERD	Glaucoma/Eye Problems	Nervous System Conditions
AIDS/HIV	Gout	Neuralgia
Atherosclerosis	Hay Fever/allergy	Night Sweats/Nightmares
Arteries/Bleeding	Heart disorder/murmur	Osteoarthritis
Artificial Joints (hip, knee)	Head Injury/Concussion	Osteoporosis (Fosamax, etc)
Asthma	Headaches	Pacemaker
Autoimmune disorder	Heart palpitations	Psychiatric Care/Counseling
Anemia/Bleeding disorder	Heart Disease/Heart Condition	Prostate Disease
Blood pressure-High/Low	Hepatitis	Radiation Treatment
Blood sugar problems	Herpes/STD	Rheumatic Fever
Bleeding Disorders	Hypoglycemia	Sinus problems
Cancer/Chemotherapy	Injury to face or neck	Steroid Use
Chemical Additions/Tx	Insomnia	Sleep apnea/snoring
High Cholesterol	Intestinal disorders/IBS/Crohns	Stroke
Chronic Fatigue	Kidney problems	Supplements/Vitamins
Cosmetic Surgery	Liver disease	Swelling
Chronic Cough	Lung conditions	Thyroid disorder
Depression/Anxiety	Medical Marijuana Use	Tuberculosis
Diabetes/Blood Sugar	Mental Health Condition	Ulcers
Difficulty sleeping	Migraines	Weight loss medication:
Dizziness	Muscle spasms/cramps	(FenPhen)
Fibromyalgia	Neck/back/spine conditions	**Other: use back or separate sheet**

Medications, supplements, other: (use back if necessary):_____

_____

_____

SURGICAL OPERATIONS YOU HAVE HAD (please circle those that apply)**:**

Digestive System	Bones or Joints	Throat or palate
Back or spine	Lung	Periodontal
Ear	Nasal or Sinus	Brain or Nervous System
Neck	Thyroid	Oral Surgery
Heart	Tonsillectomy	

Other:_____

SOCIAL HISTORY:

Tobacco use:_____Never Smoked ____Cigarettes _____Pipe ____Snuff ___Cigar ___Chew

Do you drink:_____Soda pop____Sparkling water _____Alcohol

Caffeine Intake: None_____ Coffee/Tea/Soda_____ #cups per day_____

Additional: Regular exercise: [ ] No [ ] Yes: _____ (Women) Started menopause [ ] No [ ] Yes

DENTAL HISTORY QUESTIONNAIRE

Your most recent Dentist:_____ Date of last dental visit:_____
Do you have any dental concerns now?_____
Do you have or have you ever had: (Please circle all that apply)
[ ] Orthodontics (braces)
[ ] A splint or nightguard
[ ] Periodontal (gum disease)
[ ] Problems with Novocain
[ ] Complications with dental procedures?
[ ] TMJ Problems
[ ] Painful or bleeding gums
[ ] Jaw joint noises
[ ] Nitrous oxide/Laughing gas
[ ] Problems keeping mouth open

*Other:

___Are you in a field in which your appearance or speech are important? Why:
___Have you ever whitened or bleached your teeth?
___Are you nervous about dental care?
___Do you use breath mints/etc. regularly?
___Do you use an automatic toothbrush?
___Do you chew gum regularly?

Bite/Jaw Concerns:
___A mismatched bite
___Is it hard to relax your jaw?
___Is your bite uncomfortable?
___Your teeth seem chipped or worn down?
___Clenching
___Grinding
___Difficulty breathing through your nose?
___Do you bite your tongue or cheeks often?
Other_____
_____

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

Doctors Notes: