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: _____ 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. (Our returned check fee is $30.00.)

Insurance Information: *We will gladly submit your insurance claim and any necessary information at each visit, as a service. It is your responsibility to follow up with your insurance company for payment. Please let us know if you have any questions.*

Please bring insurance cards to your appointment(s).

Insured's name:_____
Employer's name:_____
Insured's date of birth:_____

Consent and Release of Information

I authorize the release of a full report of examination findings, diagnoses, treatment program, etc. to any referring or treating dentist or physician. I authorize Dr. Mark 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: _____

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What Are Your Rights?

You have the right to:

- Request restrictions on certain uses and disclosures of your health information.
- Request that our office communicate your health information privately, with no other family members present or through mailed communications that are sealed and labeled.
- To read and read and review any an all copies of your health information including your complete chart, x-rays, and billing records. There will be a reasonable fee for duplication of your records.
- Ask us to update or modify your records if you believe that your health information records are incomplete or incorrect. There must be a reasonable reason for this change and our office reserves the right to deny this request if the records in question are not created by our office or are inaccurate.
- Request a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations. Please limit these requests to no more than six years at a time. There may be a reasonable charge for these duplications.
- To obtain a copy of these privacy notices directly from our office at any time.
- To express complaints to us or the Secretary of Health and Human Services if you believe that your privacy rights have been compromised. We encourage you to express any concerns that you may have. Thank you for communicating your complaints in writing.

We are required by law to maintain the privacy of your health information and provide you and/or your representative this notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If there is a change, we will be sure that each patient receives a copy of the revised Notice. By signing below, I give the TMJ and Sleep Solutions permission to use the contact information I have provided to confirm appointments and contact me via phone, e-mail, or USPS.

Patient Acknowledgement

Patient Name(s)_____

Thank you very much for taking the time to review our procedures in protecting your private health information. If you have any questions, please feel free to ask any member of the staff in our office. Please sign and return this form to acknowledge your understanding of the information.
Thank you!

Signature: _____
*Date:*_____

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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?_____Why?_____

LIST ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:
_____
_____
_____

PAST MEDICAL HISTORY:

- ☐ Acid reflux/GERD
- ☐ AIDS/HIV
- ☐ Artificial joints (hip, knee)
- ☐ Asthma
- ☐ Autoimmune disorders
- ☐ Blood pressure (high or low)
- ☐ Bleeding disorders
- ☐ Cancer/chemotherapy
- ☐ Chemical addictions/Treatment
- ☐ High cholesterol
- ☐ Chronic fatigue/fibromyalgia
- ☐ Cosmetic surgery
- ☐ Depression/anxiety
- ☐ Diabetes/blood sugar
- ☐ Difficulty sleeping
- ☐ Glaucoma/eye problems
- ☐ Head injury/concussion
- ☐ Headaches
- ☐ Heart disease/heart condition
- ☐ Hepatitis
- ☐ Herpes/STD
- ☐ Injury to face or neck
- ☐ Intestinal disorders
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung conditions
- ☐ Medical marijuana use
- ☐ Migraines
- ☐ Neck/back/spine conditions
- ☐ Neuralgia
- ☐ Chronic sinusitis
- ☐ Nasal drainage
- ☐ Night sweats/nightmares
- ☐ Osteoarthritis
- ☐ Osteoporosis (Fosamax, etc.)
- ☐ Pacemaker
- ☐ Prostate disease
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Sleep apnea/snoring
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight loss medication (Fen-Phen)
- ☐ Difficulty breathing through nose
- ☐ Other: Use back of form

MEDICATIONS/SUPPLEMENTS:
_____
_____
_____
_____

PAST SURGICAL HISTORY:
_____
_____
_____

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SOCIAL HISTORY: Marital status:_____ Occupation:_____

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

Alcohol consumption:

- ☐ Never
- ☐ Occasional
- ☐ Frequent

FAMILY HISTORY: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your children: _____

REVIEW OF SYSTEMS:

Constitutional:	☐ Weight loss	☐ Chills	☐ Poor appetite	☐ Fatigue
	☐ Weight gain	☐ Insomnia	☐ Night sweats	
Eyes:	☐ Blurry vision	☐ Eye pain	☐ Eye discharge	
ENT:	☐ Sore throat	☐ Hoarseness	☐ Ear pain	☐ Hearing loss
	☐ Congestion	☐ Tinnitus	☐ Sinus problems	
Cardiovascular:	☐ Chest pain	☐ Palpitations	☐ Rapid heart rate	
Respiratory:	☐ Shortness of breath	☐ Chronic cough		
Gastrointestinal:	☐ Nausea	☐ Vomiting	☐ Frequent heartburn	☐ Trouble swallowing
Skin:	☐ Skin sore or ulcers	☐ Mole changes		
Musculoskeletal:	☐ Joint pain	☐ Muscle aches	☐ Frequent leg cramps	
	☐ Muscle weakness	☐ Joint swelling	☐ Back pain	
Psychiatric:	☐ Anxiety	☐ Depression	☐ Alcohol or drug dependence	☐ Panic attacks
	☐ Use of antidepressants			
Endocrine:	☐ Heat intolerance	☐ Cold intolerance	☐ Increased thirst	
	☐ Excess sweating			
Neurological:	☐ Seizures	☐ Migraines	☐ Numbness	☐ Dizziness/vertigo
	☐ Loss of balance	☐ Slurred speech	☐ Stroke	
Hem/Lymphatic:	☐ Swollen lymph node	☐ Prolonged bleeding	☐ Blood clots	
Allergic/Immune:	☐ Allergic reactions	☐ Hay fever	☐ Frequent infections	☐ Hepatitis
	☐ HIV positive			

DENTAL HISTORY:

Your most recent dentist: _____Date of last dental visit: _____

Do you have dental concerns now? _____

Have you had: (Check all that apply)

☐ Orthodontics (braces) ☐ Implants ☐ Splint/nightguard ☐ Jaw surgery ☐ Periodontal disease (gum disease) ☐ Unusual oral issues/procedures/complications

☐ Problems keeping mouth open

Bite/Jaw Concerns:

☐ Mismatched bite ☐ Hard to relax jaw ☐ Uncomfortable bite ☐ Teeth chipped or worn down ☐ Clenching ☐ Grinding ☐ Difficulty breathing through nose ☐ Trouble swallowing

Other: _____

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

_____
_____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____
_____
_____

Please use the back of this form for any additional information if necessary.

_____
Signature of Reviewing Physician Date

_____
Signature of Patient Date