TMJ & Sleep Solutions
Mark J. Barnes, DDS

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. (Our returned check fee is $30.00)

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. Mark Barnes, D.D.S., PC and his associates to release and 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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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: _____

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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: _____ 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)?

_____

_____

_____

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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