TMJ & SLEEP SOLUTIONS

ADVANCED TECHNOLOGY • COMPASSIONATE CARE • TRUSTED EXPERIENCE

Patient Name: ____
First MI Last

Date of Birth: __/______/______ How do you wish to be addressed (nickname): ______________________

☐ Male ☐ Female ☐ Other: ______________

Whom may we thank for your referral? ____

What can we help you with today? ____

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Street Address: ___________________________ City: ______________ State: ________ Zip:__________

Home Phone number : ______________________ Cell Phone number: ______________________

Email address: ___________________________

Emergency Contact: ___________________________ Phone number: ____________________

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. Edwards, D.D.S., PC to release any information pertinent to my diagnosis or treatment to any third party participating in my health care or insurance coverage.

I certify the medical history and information I have provided is complete and accurate.

Patient Signature: ______________________________________ Date: ________________

Legal Guardian (if not patient): ______________________________ Date: ________________

Patient Name:___________________________________

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: __________________________

Occupation: ____

Alcohol consumption: ☐ Never ☐ Occasional ☐ Frequent

Smoking Habit: ☐ Non-smoker (never smoked) ☐ Ex-Smoker ☐Frequent

Dental History:

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

Have you had: (check all that apply)

☐ Orthodontics (braces) ☐ Dental Implants ☐ Splint/ Nightguard
☐ Problems keeping mouth open ☐ Trouble chewing ☐ Hard time falling asleep/staying asleep

Bite/ Jaw concerns: (check all that apply)

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

Other:____

Medical History:

Current Physician: ____ Phone number: ___________________

Date of last visit: ___________________ Reason for last visit: ____________________________________

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

Father: ____ Mother: ______________________________________
Siblings: ____
Your children: ____

Patient Name: ____

List any medications/supplements: (attach separate sheet if needed) ☐ None

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Past surgery History: ☐ None

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Trauma History: (i.e. car accident, bike accident, recreation injury, horse accident, etc.) ☐ None

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Past Medical History: ☐ None

☐ Acid reflux/ GERD/ulcer	☐ Sleep apnea/ snoring	☐ Kidney Problems	☐ Difficulty Sleeping
☐ Artificial Joints	☐ Cancer	☐ Medical marijuana use	☐ Arthritis
☐ Asthma/breathing issues	☐ Radiation treatment	☐ Neck/back/spine pain	☐ Osteoporosis
☐ Diabetes	☐ Chemotherapy	☐ High cholesterol	☐ Chronic headaches
☐ Neuralgia(s)	☐ Heart Disease/ arrhythmia	☐ Heart murmur/surgery	☐ Rheumatic fever
☐ Chronic pain condition	☐ Sinus problems	☐ Migraines	

Current Medical Symptoms:

☐ Weight Loss	☐ Chills/ Night Sweats	☐ Poor appetite	☐ Chronic Fatigue	☐ Insomnia
☐ Blurry Vision	☐ Eye Pain	☐ Eye Discharge	☐ Chronic Sore Throat	☐ Hoarseness
☐ Ear Pain	☐ Hearing Loss	☐ Vertigo	☐ Congestion	☐ Sinus Problems
☐ Tinnitus	☐ Chest Pain	☐ Palpitations	☐ Rapid heart rate	☐ Chronic couch
☐ Shortness of breath	☐ Lung Disease	☐ Chronic Nausea	☐ IBS/ Gluten sensitivity	☐ Frequent heartburn
☐ Trouble Swallowing	☐ Skin Condition	☐ Mole changes	☐ Skin Cancer	☐ Frequent leg cramps
☐ Joint pain	☐ Joint surgery	☐ Muscle aches	☐ Back/neck pain	☐ Panic attacks
☐ Anxiety/ Depression	☐ Alcohol/Drug treatment	☐ Excess thirst	☐ Excess sweating	☐ Hormone problems
☐ Heat/Cold intolerance	☐ Hypo/hyperglycemia	☐ Thyroid disease	☐ Seizures	☐ Migraines
☐ Loss of balance	☐ Speech problems	☐ Stroke	☐ Numbness	☐ Dizziness
☐ Swollen lymph nodes	☐ Bleeding disorder	☐ Blood clots		

Patient Name: ____

Allergies:

☐ Allergic Reactions	☐ Hay Fever (chronic)	☐ Frequent infections
☐ Hepatitis	☐ HIV positive	☐ Herpes/ cold sores

Other: ____

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

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____ ________________________
Signature of Reviewing Physician Date

____ ________________________
Signature of Patient/ Legal Guardian Date