Dr. Hitesh Patel

PRE-TREATMENT QUESTIONNAIRE

Please fill out this page and the information will help us quickly understand your needs and in the process provide you with excellent patient-focused service. Our patients have found that filling out this form helps them to think about what they want out of their visit and how we can help in the best way possible. So, grab a pen and let us know more about you!

I decided to make an appointment because _____

_____

My biggest concern is _____

_____

My health goals for the future are. _____

_____

I would like to learn more about _____

Once I have completed my visits I'm looking forward to _____

_____

I'm having pain or discomfort ☐ YES NO ☐

If your answer is YES, please answer these two questions:

I have the following kind of pain _____

_____

How do you rate your pain from 0 to 10 (0 is NO PAIN and 10 is MOST SEVERE PAIN): _____

When I'm free of pain I will be able to _____

How do you want your quality of life to change? _____

Patient Name: _____ Date: _____

Patient Signature: _____

Dr. Hitesh Patel
Suburban TMJ and Sleep Center
TMJ • FACIAL PAIN • SNORING • SLEEP APNEA
Center of Excellence for TMJ and Sleep

HEAD, NECK, & FACIAL PAIN QUESTIONNAIRE

☐ MR. ☐ MRS ☐ MISS ☐ DR. **TODAY'S DATE:** _____

NAME: _____

First Middle Initial Last

AGE: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

ADDRESS: _____

CITY/STATE: _____

CELL PHONE: _____ **HOME PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____

SSN#: _____

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED**

DRIVERS LICENSE#: _____ **STATE:** _____ **Copy of** ☐

***In accordance with the Federal Trade commission's Red Flag regulations to protect your medical record and identity**

EMERGENCY CONTACT PERSON (NAME AND PHONE#): _____

REFERRED BY: _____

☐ **DDS** ☐ **MD** ☐ **ENT** ☐ **DC** ☐ **OTHER:** _____

REASON FOR THIS APPOINTMENT:

☐ **FACE PAIN** ☐ **JAW PAIN** ☐ **EAR PAIN**

☐ **HEADACHES** ☐ **POPPING** ☐ **CLICKING**

☐ **FATIGUE/ BREATHING** ☐ **LIMITED OPENING** ☐ **LOCKING**

EMPLOYER NAME: _____ **PHONE:** _____

JOB TITLE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Health Care Practitioners and Patient communication

Please provide us with the name and addresses of all your doctors and healthcare providers

Family Dentist

Providers Name: _____

Street Name/City/State: _____

☐ **Orthodontist** ☐ **Oral Surgeon** ☐ **Endodontist**

Providers Name: _____

Street Name/City/State: _____

Family Physician

Providers Name: _____

Street Name/City/State: _____

Specialty Providers

Specialty: _____

Providers Name: _____

Street Name/City/State: _____

Specialty: _____

Providers Name: _____

Street Name/City/State: _____

By signing below, I am giving permission to communicate with the above-named health care providers regarding my treatment

Parent/Guardin Signature: _____ **Date:** _____

Patient Name: _____

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PREVIOUS TREATMENT/ MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

HEALTH AND MEDICAL HISTORY

Have you ever had prior orthodontic treatments? ☐ **YES** ☐ **NO**

Are you currently pregnant? ☐ **YES** ☐ **NO**

Are you currently breastfeeding? ☐ **YES** ☐ **NO**

SURGICAL HISTORY

Have you ever had your wisdom teeth removed? ☐ **YES** ☐ **NO**

Have you ever had a root canal or any tooth removal for this condition? ☐ **YES** ☐ **NO**

Have you ever had Joint Surgery? ☐ **YES** ☐ **NO**

Have you ever had Orthognathic Surgery? ☐ **YES** ☐ **NO**

Any other type of surgery?

MEDICAL HISTORY

Please check all that apply and leave all others blank. If there is anything not listed indicate the information in the OTHER section

Allergy History
- ☐ Allergy Skin Testing
- ☐ Allergen Desensitization
- ☐ Hay Fever

ENT History
- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Turbinectomy

Cancer History
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy

Eye History
- ☐ Cataract
- ☐ Visual Impairment
- ☐ Glaucoma

Pulmonary History
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Infectious Disease
- ☐ Measles
- ☐ Chicken Pox
- ☐ Smallpox
- ☐ Diptheria

Cardiac History
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rhyth Disorder
- ☐ Functional Murmur
- ☐ Mitral Valve Prolapse
- ☐ Angina Pectoris
- ☐ Prior MI
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular
- ☐ Hypertension

Gastrointestinal History
- ☐ Hepatitis
- ☐ Acute Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Esophageal Reflux
- ☐ Esophageal Ulcer
- ☐ Peptic Ulcer
- ☐ Chronic Reflux Esophagitis
- ☐ Esophagitis
- ☐ Esophageal Structure
- ☐ Hiatal Hernia

Trauma
- ☐ Facial Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Mouth Injury

Hematological History
- ☐ Anemia
- ☐ Bleeding/Clotting
- ☐ Leukemia
- ☐ HIV

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Kidney/Bladder History
- ☐ Prostate Disorder
- ☐ Renal Failure
- ☐ Stress Incontinence
- ☐ Urinary, Bladder Infections
- ☐ Kidney stones
- ☐ Urinary Calculus

Endocrine History
- ☐ Diabetes
- ☐ Thyroid Disorders
- ☐ Chronic Fatigue

Neurological History
- ☐ Epilepsy
- ☐ TIA
- ☐ Stroke Syndrome
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ Migraine Headaches
- ☐ Vascular Headaches

Musculoskeletal History
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia

OTHER HISTORY ITEMS NOT LISTED: _____

Head Pain	Location	Severity Mild------Severe			Frequency Month	Weekly	Daily	Duration Second	Minutes	Hours	Days	Weeks
L☐ R☐ B☐	**Front of your head** (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐	**Entire head** (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐	**Top of your head** (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐	**Back of your head** (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐	**In your temple** (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Jaw Pain*	Location
L☐ R☐ B☐	**Jaw pain – on openinng**
L☐ R☐ B☐	**Jaw pain – while chewing**
L☐ R☐ B☐	**Jaw pain – at rest**

MOUTH & NOSE RELATED CONDITIONS
- Y☐ N☐ Broken teeth
- Y☐ N☐ Buring tongue
- Y☐ N☐ Chronic sinusitis
- Y☐ N☐ Dry mouth
- Y☐ N☐ Frequent biting of cheek
- Y☐ N☐ Frequent snoring

EAR-RELATED CONDITIONS
- Y☐ N☐ Buzzing in the ears
- Y☐ N☐ Ear congestion
- Y☐ N☐ Ear pain
- Y☐ N☐ Hearing loss
- Y☐ N☐ Pain behind the ear
- Y☐ N☐ Recurrent ear infections
- Y☐ N☐ Tinnitus (ringing in the ear)

JAW SYMPTOMS
- Y☐ N☐ Jaw clicks
- Y☐ N☐ Jaw locks closed
- Y☐ N☐ Jaw locks open
- Y☐ N☐ Jaw popping
- Y☐ N☐ Teeth clenching
- Y☐ N☐ Teeth Grinding

EYE RELATED CONDITIONS
- Y☐ N☐ Blurred vision
- Y☐ N☐ Double vision
- Y☐ N☐ Eye pain
- Y☐ N☐ Pain or pressure behind the eyes
- Y☐ N☐ Photophobia (extreme sensitivity)

THROAT, NECK & BACK-RELATED CONDITIONS
- Y☐ N☐ Back pain – lower
- Y☐ N☐ Back pain – middle
- Y☐ N☐ Back pain – upper
- Y☐ N☐ Chronic sore throat
- Y☐ N☐ Constant feeling of A foreign object in Throat
- Y☐ N☐ Difficulty in swallowing
- Y☐ N☐ Limited movement of the neck
- Y☐ N☐ Neck pain
- Y☐ N☐ Sciatica
- Y☐ N☐ Scoliosis
- Y☐ N☐ Shoulder pain
- Y☐ N☐ Numbness in the neck, hand or Fingers
- Y☐ N☐ Shoulder stiffness
- Y☐ N☐ Swelling of neck
- Y☐ N☐ Swollen glands
- Y☐ N☐ Thyroid enlargement
- Y☐ N☐ Wryneck
- Y☐ N☐ Tingling in the hands or finger

Y☐ N☐ **Other:** _____

Patient Signature: _____ **Date:** _____

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History of Symptoms

When did your condition first occur?

What do you believe is the cause of your pain or condition?

PICK ONE: ☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related incident ☐ Accident
☐ Playground incident ☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Illness ☐ Injury
☐ Unknown ☐ Other: _____ If accident, date: _____

Is there anything that makes your pain or discomfort worse?

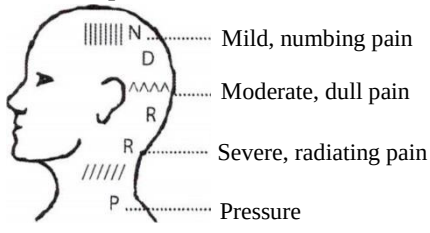
Is there anything that makes your pain or discomfort better?

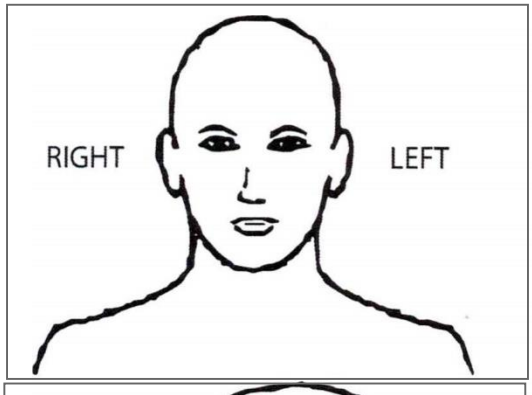
What other information is important to your pain or condition?

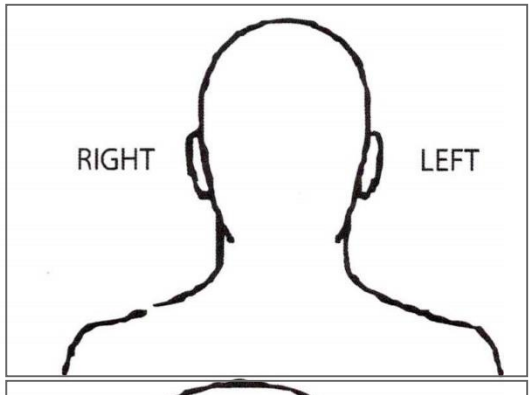
Draw your pain patterns following this key:

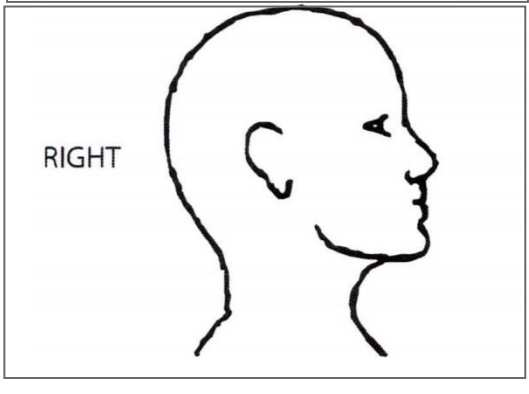
MILD PAIN……..|||||||||| **B**……Burning
D……Dull
N……Numbing
MODERATE PAIN……...^^^^ **P**……Pressure
S……Sharp
T……Tingling
SEVERE PAIN……////// **R**……....Radiating

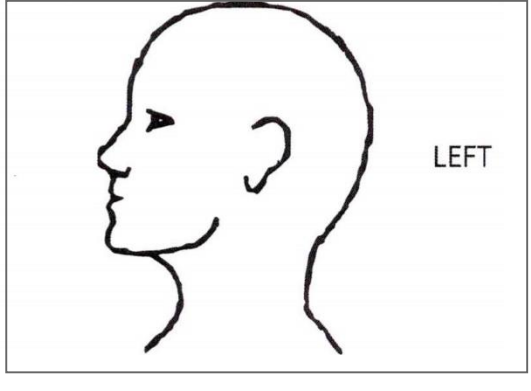
Example











Patient Signature: _____ Date: _____

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What are the chief complaints for which you are seeking treatment	
Please rate your complaints for intensity	(0 is NO PAIN and 10 is MOST SEVERE PAIN)
Ear Pain	
Headaches	
Inability to open your mouth	
Jaw Clicking	
Jaw Joint Noises	
Jaw Pain	
Limited Mouth Opening	
Migraine Headaches	
Muscle Twitching	
Locking	
Pain when Chewing	
Other	

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TMJ HISTORY

TELL US YOUR TMJ HISTORY: _____

_____

_____

_____

When did your condition first occur? _____

Is there anything that makes your pain or discomfort worst? _____
(Please describe)

Is there anything that makes your pain and discomfort better? _____
(Please describe)

What other information is important to your pain or condition? _____

_____

ALLERGIC REACTIONS

Please list all medication and check any substances that have caused an ALLERGIC reaction

☐ **ANESTHETICS** ☐ **IODINE** ☐ **LATEX** ☐ **METALS**

☐ **OTHER:** _____

CURRENT MEDICATIONS

MEDICATIONS	**DOSAGE**	**REASON FOR TAKING**

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services and/or co-payments is due at the time services are rendered.
Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for failed appointments and appointments canceled without 24-hour advanced notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not part of that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above info or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient Signature: _____ Date: _____

Hitesh K. Patel D.D.S. D.A.AP.M., D.A.C.S.D.D., F.I.C.C.M.O., F.A.D.I., F.I.C.D., General Dentist
Diplomate, American Academy of Pain Management, Diplomate, American Academy of Clinical Sleep Disorders Disciplines
Fellow, international. Fellow American College of Dentists. Fellow, International College of Dentists

Notice of Privacy Practices/HIPAA Acknowledgement

The Health Insurance Portability and Accountability act of 1996 (HIPAA), established Privacy Rule to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient consent for the uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information regarding treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

We may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Be sure to review the Notice of Privacy Practices for important information about your rights under HIPAA.

By signing below, you acknowledge that the Notice of Privacy Practices was made available for your review if you request it, you had the opportunity to request a copy for yourself and may view the document on our website.

Signature: _____ Date: _____

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