Dental Wellness Center

Robert P. McBride, D.D.S., M.A.G.D

TMJ Patient Information

Dental Wellness Center
5406 E. Village Road
Long Beach , CA , 90808

(562) 421-3747
www.LongBeachHolisticDentist.com
leanne@rpmdentistry.com

Patient Details

Last Name _____ First Name _____ Middle Name _____ Pronunciation: _____

I prefer to be called: _____ Birth Date: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Residence Phone: _____ Cell Phone: _____ Fax: _____

Email ID: _____

If less than one year, previous address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Driver's License No. _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Spouse Details

Marital Status: _____ Spouse SS# _____

Name of Spouse: Last _____ First _____ Middle _____

Spouse's Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Relative's Details

Name of nearest relative not living with you: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Work Phone: _____

Who is legally responsible, if other than the patient? Last Name _____ First Name _____ Middle Name _____

Relationship to patient: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

How did you find out about the Dental Wellness Center? _____

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Dental Insurance

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Insurance benefits vary considerably from contract to contract. In spite of our efforts, we find it impossible to be sure what you will get back ... it's very frustrating.

Although we are not contracted with any dental insurance companies, for those of you that have dental insurance that allows freedom of choice of dentists, we fully commit to obtaining any and all benefits that lie within your contract. If you would be interested in learning why we are not contracted with 3rd parties, go to our website, www.LongBeachHolisticDentist.com, click the "Resources" tab, go to articles, and scroll down to the "Dental Insurance Misnomer" article.

The financial obligation for dental treatment is between you and our office - your insurance company is responsible to you, and not to our office. We will assist you in any way that we can.

To expedite your receiving all benefits due you, please fill out the following:

Name of Insured : _____

Birth date: _____ Social Security Number: _____

Employer Name: _____

Insurance company (Carrier) name: _____

Name of Group Plan: _____ Group number: _____

Address of insurance company: _____

City: _____ State: _____ Zip Code: _____

Phone number of insurance company: _____

If you have secondary dental insurance:

Name of other insured party: _____

Social Security Number: _____ Date of Birth of other insured party: _____

Employer Name: _____

Insurance company (Carrier) name: _____

Name of Group Plan: _____ Group number: _____

Address of insurance company: _____

City: _____ State: _____ Zip Code: _____

Phone number of insurance company: _____

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Financial Menu

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Client: _____ Date: _____

Dental treatment is an excellent investment in an individual's physical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

PAYMENT OPTIONS:

Two Payments (for treatment over $1,000 that have more than one visit)
Total patient obligation may be divided as follows: 50% due at the first treatment visit, with the remaining balance paid at last visit. For any fees under $1,000, the full amount is due at the initiation of any procedure.

Treatments today ... Payments tomorrow ...
We are pleased to offer Care Credit. It is convenient, no initial payment, low monthly payment plan for dental treatments of $200 to $25,000. Offering Care Credit allows us to make the smile you've always wanted affordable.

Apply from home:
Care Credit: 1-800-365-8295

Apply online 24 hours, 7 days a week:
Care Credit: www.carecredit.com

Pay as You Go. You may choose to pay your entire obligation for each visit, at the visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): **Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks or Care Credit (see above).**

I have read and understand all the above _____
Patient Signature

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Provider Information

Family Physician: _____ Date of last visit: _____
Specialty: _____ Date of last complete physical: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # with Area Code: _____

Additional Physician: _____ Date of last visit: _____
Specialty: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # with Area Code: _____

Additional Physician or Health Provider, such as Chiropractor, Naturopath, Homeopath, Acupuncturist, etc.
_____ Date of last visit: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # with Area Code: _____

_____ Date of last visit: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # with Area Code: _____

_____ Date of last visit: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # with Area Code: _____

Please check areas that apply to you

- ☐ Alcohol: # drinks daily _____
- ☐ Anemia
- ☐ Angina
- ☐ Ankle Swelling
- ☐ Artificial Heart Valve
- ☐ Artificial Joints, Plates, Screws
- ☐ Asthma
- ☐ Atherosclerosis
- ☐ Auto Immune Condition
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Lesions
- ☐ Diabetes/Prediabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fatigue Easily
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis: A B C
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Nervousness /Depression
- ☐ Osteoarthritis
- ☐ Periodontal Disease
- ☐ Prophylactic antibiotics before cleaning or dental treatment
- ☐ Radiation (Head / Neck)
- ☐ Recreational Drugs, such as marijuana, stimulants, depressants that may have a fatal with local anesthetics or other common dental medications?
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Snore or gasp for air during sleep
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Women Only

- ☐ Birth Control
- ☐ Nursing
- ☐ Pregnant: *Delivery Date*

Are currently being treated for any of the above conditions? ◯ Yes ◯ No Which one(s)? _____
If being treated for another condition, please describe: _____
Current Weight: _____ Current Height: _____
Have you ◯ gained ◯ or lost weight within the last year? If so, How much? _____

Please check if you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Latex
- ☐ Anesthetic
- ☐ Nitrous Oxide
- ☐ Sulfa
- ☐ Percodan
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Other Allergies

Please list other allergies.

Please check if you have ever taken any of the following drugs

- ☐ Fosamax
- ☐ Aredia
- ☐ Didronel
- ☐ Actonel
- ☐ Zometa
- ☐ Skelid
- ☐ Boniva
- ☐ Biphosphonates
- ☐ Phen Fen

Please list ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please name the pharmacy you use: _____

City: _____ Phone: _____

Are you taking vitamins; food supplements; herbal preparations? Please list.

Please feel free to offer any dental or medical information below that would assist us in getting to know you better

Sleep Disordered Breathing is highly prevalent in the U.S. population. This brief survey has been quite useful in discovering whether this possibility exists.

Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?

No chance of dozing = 0 | **Slight chance of dozing = 1** | **Moderate chance of dozing = 2** | **High chance of dozing = 3**

_____ Sitting and Reading

_____ Watching TV

_____ Sitting inactive in a public place, ie... theater or a meeting

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon if conditions permit

_____ Sitting and talking to someone

_____ Sitting quietly after lunch without alcohol

_____ In a car, while stopped for a few minutes in traffic

_____ TOTAL SCORE

Is there a disease or condition not listed above that you think I should know of? ◯ Yes ◯ No If Yes, what?

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify The Dental Wellness Center of any changes. I understand that if I withhold information regarding allergies, medical conditions, medications, or supplements, I agree not to hold The Dental Wellness Center or its employees liable in the event of death or injury. Authorization is given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature (Patient / Guardian) _____ Date _____ Dentist Signature _____

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Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration of your individual needs.

Specialty Dentist: _____ Period of Treatment : _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

Date of last complete x-rays? ____/____ Date of last oral cancer screening ____/____ Date of last cleaning? ____/____

What is the primary reason you selected the Dental Wellness Center? _____

Please check conditions that apply to you

- ☐ Sensitivity to: ☐ Pressure from biting or chewing ☐ Hot ☐ Cold ☐ Sweet
- ☐ Chipped/Broken Teeth
- ☐ Teeth wearing away abnormally
- ☐ Crooked or Tipped Teeth
- ☐ Loose Teeth
- ☐ Missing Teeth
- ☐ Gaps/Food Traps between teeth
- ☐ Dry Mouth or Constantly Thirsty
- ☐ Burning Sensation in Mouth/Tongue
- ☐ Smoke or Use Chewing Tobacco
- ☐ Growths or Swellings in Mouth
- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Grooves or Recession at Gumline
- ☐ Allergic to Dental Materials
- ☐ Oral Malodor (Bad Breath)
- ☐ Bad Taste
- ☐ Dissatisfied With Appearance of My Teeth
- ☐ Teeth Clenching ☐ Teeth Grinding
- ☐ Uncomfortable Bite ☐ Uneven Bite
- ☐ Changing Bite
- ☐ Jaw Joint (TMJ) Pain/Soreness/Discomfort Jaw Joint
- ☐ (TMJ) Noise (Popping/Clicking)
- ☐ Ringing in The Ears (tinnitus)
- ☐ Difficulty in Opening Mouth ☐ Difficulty in Chewing
- ☐ Headaches/Migraines
- ☐ Pain or Soreness Around ☐ Eyes ☐ Ears
- ☐ Vertigo, Dizziness or Balance Problems
- ☐ Pain ☐ Stiffness ☐ Facial ☐ Head ☐ Neck ☐ Shoulder

Please check all areas that apply to you

- ☐ Dentures or Removable Partial Dentures
- ☐ Fixed Bridge
- ☐ Braces or Clear Braces
- ☐ Dental Implants
- ☐ Crowns
- ☐ Veneers
- ☐ Any Serious Trouble With Past Dental Treatment
- ☐ Unusual Reaction to Dental Anesthesia ("Shots") Jaw
- ☐ Surgery
- ☐ Root Canals
- ☐ Sleep Apnea
- ☐ CPAP Machine or Sleep Appliance
- ☐ Night Guard
- ☐ Fear or anxiety level regarding dental treatment

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

If I could change my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Fillings With Tooth Colored Replacements
- ☐ Fix My Teeth So I'm Not Embarrassed To Smile
- ☐ Repair Chipped Teeth
- ☐ Fix "Gummy" Smile
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Don't Fit Right or Match
- ☐ Have A Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking
- ☐ Stop My Gums From Bleeding

On a scale of 1 - 10, with 10 being the highest rating:

	1	2	3	4	5	6	7	8	9	10
How important is your dental health to you?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Where would you rate your current dental health?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Family Medical/Dental History

Please check any condition that applies to your parents (Mother/Father)

Heart disease	☐ Mother	☐ Father	Cancer	☐ Mother	☐ Father
Heart attack	☐ Mother	☐ Father	Pre-term birth	☐ Mother	☐ Father
High blood pressure	☐ Mother	☐ Father	Gum disease	☐ Mother	☐ Father
Stroke	☐ Mother	☐ Father	Tooth loss	☐ Mother	☐ Father
Low blood pressure	☐ Mother	☐ Father	Dentures	☐ Mother	☐ Father
Diabetes	☐ Mother	☐ Father			

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Please answer all questions to the best of your ability - use additional paper if necessary.

1. Describe your problem

2. Do you have a clicking, popping or grating noise in your
   Right Jaw Joint ◯ Yes ◯ No
   Left Jaw Joint ◯ Yes ◯ No

3. When did you first notice the noise?
   Right: _____ Left: _____

4. Has the noise recently become more pronounced? ◯ Yes ◯ No
   When? _____

5. Do you have pain in or around the right joint? ◯ Yes ◯ No
   Do you have pain in or around the left joint? ◯ Yes ◯ No

6. When did you first notice the pain?
   Right: _____ Left: _____

7. Is the pain worse:
   ☐ Mornings: ☐ At Meals:
   ☐ Evenings: ☐ No Specific Time:

8. Has the pain recently become more pronounced? ◯ Yes ◯ No
   When? _____

9. Is the pain:
   ☐ Dull, achy ☐ Continuous ☐ Sharp, Stabbing
   ☐ Intermittent ☐ Throbbing
   ☐ If other, please describe: _____

10. Does the pain sometimes feel like it's in your ear? ◯ Yes ◯ No

11. Do you think this problem has affected your hearing? ◯ Yes ◯ No

12. Do you hear a ringing noise (tinnitus)? ◯ Yes ◯ No
    ☐ Constant ☐ Intermittent

13. Do you have vertigo (periods of dizziness)? ◯ Yes ◯ No

14. Does your jaw problem interfere with your normal activities? ◯ Yes ◯ No

15. Do you have any idea what triggered the problem, what caused it, or what makes the problem continue? ◯ Yes ◯ No

Explain

16. Do you have frequent headaches or neckaches? ◯ Yes ◯ No

What Area(s)? _____

How Frequent? _____

17. Have you ever had a severe blow or trauma to the head, neck, or jaw? ◯ Yes ◯ No

Which area? _____

Explain: _____

18. Do you have difficulty chewing? ◯ Yes ◯ No

☐ Because of Pain in Joint ☐ Limited Opening ☐ Pain in Teeth

☐ Missing Teeth ☐ Clicking

☐ Other: _____

19. Has your mouth ever locked open so you were unable to close it? ◯ Yes ◯ No

Explain

20. Have you had problems opening your mouth wide? ◯ Yes ◯ No

Explain

21. Do you feel as if your teeth don't have a "home base" to close to, or that your bite is changing? ◯ Yes ◯ No

22. Have you ever been told that you grind your teeth during sleep? ◯ Yes ◯ No

23. Please indicate the time sequence in which you became aware of the following problems list. Number only those problems that apply to you. ◯ Yes ◯ No

Pain: _____ Noise: _____ Limited opening: _____

Locking: _____ Other: _____

24. Which aspects of your problem concern you the most?

Explain

25. Are you aware of clenching your teeth? ◯ Yes ◯ No

26. Do you grind your teeth? ◯ Yes ◯ No

27. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in the immediate family or other stressful events? ◯ Yes ◯ No

Explain

28. Do you have young children under your care? ◯ Yes ◯ No

29. Do you smoke a pipe? ◯ Yes ◯ No

Do you chew gum? ◯ Yes ◯ No

Do you bite your nails? ◯ Yes ◯ No

Do you have any other nervous habits? ◯ Yes ◯ No

30. Describe any habits at work or home which might place your body in a strained or awkward posture (such as holding a phone with a shoulder or carrying equipment.

31. Do you think nervous tension seems to affect this problem? ◯ Yes ◯ No

Explain

32. Have you had problems with other joints? ◯ Yes ◯ No

Explain

33. Is there any history of similar problems in your family? ◯ Yes ◯ No

34. Have you had orthodontic treatment? ◯ Yes ◯ No

When? _____ Where? _____

35. Have you had recent dental treatment? ◯ Yes ◯ No

If yes, when? _____

Where? _____

36. Describe your past dental treatment in general.

37. Have you ever had x-rays taken of your jaw joints? ◯ Yes ◯ No

When? _____ Where? _____

38. List the names of all the health professionals you have seen for treatment of this problem, chronologically.

A. _____ E. _____

B. _____ F. _____

C. _____ G. _____

D. _____ H. _____

39. Discuss the relative success of your prior treatment(s).

40. List all medications you are (a) now taking, (b) have taken for this problem.

_____ _____

_____ _____

_____ _____

41. Please comment on your nutrition.

42. Do you use vitamins? ◯ Yes ◯ No

If yes, name and give dosage. _____

43. Do you smoke? ◯ Yes ◯ No

How much? _____

44. Comment on your sleep patterns: Such as – time you go to sleep, sleep positions, amount of sleep, etc.

45. Are you afraid your problem is serious? ◯ Yes ◯ No

46. Any ideas as to what should be done?

47. **Your medical history:**

a. Are you under current medical care? ◯ Yes ◯ No

If yes, for what? _____

b. Any major illness or operations? ◯ Yes ◯ No

What? _____

When? _____

c. Are you now taking any drugs or medications other than what you might have mentioned in question #40? ◯ Yes ◯ No

If yes, please note. _____

d. Do you have any adverse reactions to drugs? ◯ Yes ◯ No

If yes, please note. _____

e. Do you consider yourself in good health? ◯ Yes ◯ No

Please comment

48. Please add to the above information if you wish.

Signature: _____ Date: _____