



TMJ & Sleep Therapy Centre of the South Shore

Alison T. Freeman, DMD

NEW PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Date: _____

- Name (Last, First): _____, _____ DOB: _____
- Gender: _____ Preferred pronoun: _____
- Cell phone: _____ Home phone: _____
- Email: _____
- Address: _____
- Guardian (for minor): _____

HEALTH HISTORY

Briefly describe the reasons that prompted your consultation appointment:

Who referred you to our office?

- Name: _____
- Dentist / physician / past patient / friend / online referral / other _____
- Phone number: _____
- Address: _____
- Email: _____

Date of last dental exam/ Name of your dentist: _____

Date of last physical exam/Name of your PCP/Internist: _____

Have you had any jaw, face, head, or neck imaging in the past 2 years? (panoramic x-ray, CBCT, MRI etc.) If yes, bring reports or scans to your appointment.

Current medications/supplements being taken, dose, and reason:

Medications recently stopped: _____

Allergies to medications/latex/foods: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

MEDICAL CONDITIONS

Do you have a history of:

• <u>Widespread and chronic body pain</u>	Y / N
• <u>Fibromyalgia</u>	Y / N
• <u>Consultations with a rheumatologist</u>	Y / N
• <u>Arthritis (osteoarthritis/rheumatoid/psoriatic etc.)</u>	Y / N
• <u>Autoimmune problems (Sjogrens/lupus etc.)</u>	Y / N
• <u>Genetic connective tissue disorders (Ehlers Danlos syndrome etc)</u>	Y / N
• <u>Persistent tension or migraine headaches</u>	Y / N
• <u>Consultations with a headache specialist</u>	Y / N
• <u>Gastrointestinal problems (IBS/ reflux/hiatal hernia/ulcers/Crohn's)</u>	Y / N
• <u>Neuropathies or nerve pain disorders</u>	Y / N
• <u>Lyme disease</u>	Y / N
• <u>Osteoporosis/osteopenia</u>	Y / N
• <u>Emotional distress</u>	Y / N
• <u>Anxiety/Depression</u>	Y / N
• <u>Psychiatric treatment</u>	Y / N
• <u>Heart problems</u>	Y / N
• <u>High or low blood pressure</u>	Y / N
• <u>Past stroke</u>	Y / N
• <u>Diabetes</u>	Y / N
• <u>Thyroid/parathyroid disease</u>	Y / N
• <u>Past cancer treatment (radiation/chemotherapy/surgery)</u>	Y / N
• <u>High cholesterol</u>	Y / N
• <u>Anemia or other blood disorder</u>	Y / N
• <u>Prolonged bleeding due to slight cut</u>	Y / N
• <u>Cardiac stent within the last six months</u>	Y / N
• <u>History of infective endocarditis</u>	Y / N
• <u>Artificial heart valve, repaired heart defect (PFO)</u>	Y / N
• <u>Pacemaker or implantable defibrillator</u>	Y / N
• <u>Artificial prosthesis (heart valve or joints</u>	Y / N
• <u>Emphysema, shortness of breath, other respiratory problems</u>	Y / N
• <u>Asthma</u>	Y / N
• <u>Kidney disease</u>	Y / N
• <u>Liver disease</u>	Y / N
• <u>Glaucoma</u>	Y / N
• <u>Epilepsy, convulsions (seizures)</u>	Y / N
• <u>Neurologic disorders</u>	Y / N

- Ongoing or frequent viral infections and cold sores Y / N
- Common allergies /hives/ skin rash/hay fever Y / N
- STI/STD Y / N
- Hepatitis (type) Y / N
- HIV / AIDS Y / N
- Other (please explain) _____

Are you:

- Aware of a change in your health in the last 24 hours (fever, chills, new cough, or diarrhea) Y / N
- Pregnant Y / N
- Breastfeeding Y / N
- Taking birth control pills Y / N

Past hospitalizations and surgeries (date and reason):

Past accidents and injuries?

Do you use alcohol? If yes, frequency? _____

Do you use nicotine? If yes, frequency? _____

Do you use any other drugs? If yes, what type and how much?

Additional Symptoms – Head Pain Please complete for all that apply:

1. **Do you experience General Head Pain?** ☐ Yes ☐ No

	Location			Recent/Chronic		Severity			Duration			Frequency		
	L = Left	R = Right	B = Both		(over 6mo.)	Mild	Mod	Severe	Hrs	Days	Wks	Occ.	Freq	Constant
2. Temple Area	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Back of Head	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Forehead	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Top of Head	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For the below categories, please indicate L or R, if applicable

Jaw Pain ☐ I have no jaw pain

Jaw pain with opening ☐ L ☐ R

Jaw pain when chewing ☐ L ☐ R

Jaw pain at rest ☐ L ☐ R

Jaw Joint Sounds ☐ I have no jaw joint sounds

Jaw sounds with opening ☐ L ☐ R

Jaw sounds when chewing ☐ L ☐ R

Ear Related Conditions

Buzzing in ears ☐ L ☐ R

Ear Congestion ☐ L ☐ R

Ear pain ☐ L ☐ R

Hearing Loss ☐ L ☐ R

Itchiness/stuffiness ☐ L ☐ R

Pain behind the ear ☐ L ☐ R

Pain in front of ear ☐ L ☐ R

Recurrent ear infections ☐ L ☐ R

Ringing in the ear (tinnitus) ☐ L ☐ R

For the below categories, please respond with Yes or No DO NOT LEAVE BLANK

Jaw Locking

Jaw locks closed ☐ Yes ☐ No

Jaw locks open ☐ Yes ☐ No

Jaw Joint Symptoms

Teeth clenching ☐ Yes ☐ No ☐ Day ☐ Night

Teeth grinding ☐ Yes ☐ No ☐ Day ☐ Night

Eye Related Conditions

Blurred vision ☐ Yes ☐ No

Double vision ☐ Yes ☐ No

Eye pain ☐ Yes ☐ No

Pain or pressure behind the eyes ☐ Yes ☐ No

Extreme sensitivity to light ☐ Yes ☐ No

Wear of glasses or contacts ☐ Yes ☐ No

Throat Related Conditions

Chronic sore throat ☐ Yes ☐ No

Difficulty Swallowing ☐ Yes ☐ No

Swollen glands ☐ Yes ☐ No

Thyroid enlargement ☐ Yes ☐ No

Tightness in throat ☐ Yes ☐ No

Feeling of foreign object in throat ☐ Yes ☐ No

Neck related Conditions

Limited movement ☐ Yes ☐ No

Neck pain ☐ Yes ☐ No

Numbness in hands/fingers ☐ Yes ☐ No

Swelling in neck ☐ Yes ☐ No

Shoulder Conditions

Pain in Shoulders ☐ Yes ☐ No

Stiffness in Shoulders ☐ Yes ☐ No

Tingling in fingers/hands ☐ Yes ☐ No

Back Conditions

Low Back Pain ☐ Yes ☐ No

Middle Back Pain ☐ Yes ☐ No

Upper Back Pain ☐ Yes ☐ No

Scoliosis ☐ Yes ☐ No

Sciatica ☐ Yes ☐ No

Mouth/Nose Conditions

Chronic Sinusitis ☐ Yes ☐ No

Dry Mouth ☐ Yes ☐ No

Frequent Snoring ☐ Yes ☐ No

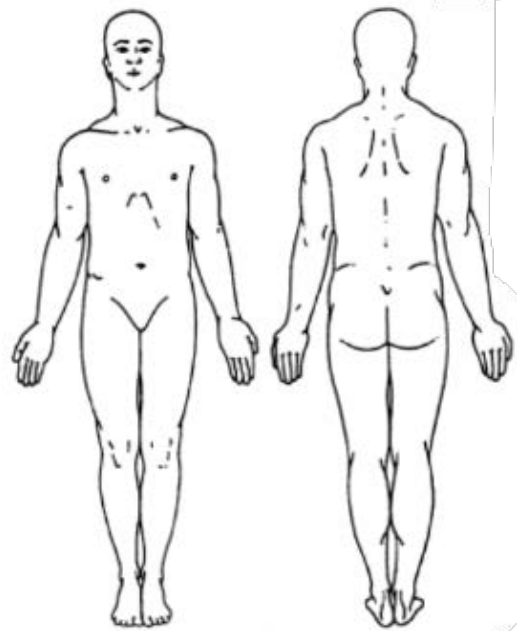
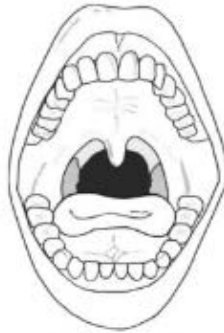
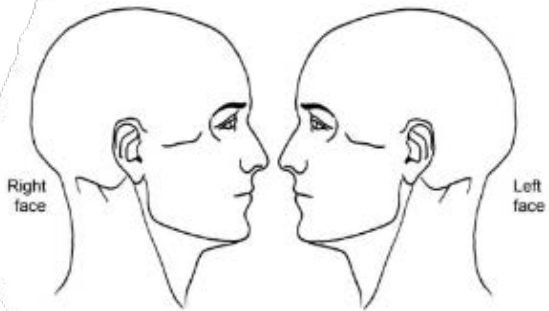
Broken Teeth ☐ Yes ☐ No

Biting Cheeks ☐ Yes ☐ No

Burning Tongue ☐ Yes ☐ No

Patient/Parent Signature: _____ Date: _____

PAIN DIAGRAMMS



Over the last 2 weeks , how often have you been bothered by the following problems? (Use “✓” to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

DENTAL SLEEP HEALTH QUESTIONNAIRE

How would you and your sleeping partner answer these questions?

Name: _____ Date _____

- | | | |
|--|----------------|-------|
| 1. Do you snore or have been told by someone that you snore? | ___yes (2 pts) | ___no |
| 2. Has anyone ever noticed that you stopped breathing during your sleep? | ___yes (3 pts) | ___no |
| 3. Do you ever awaken with a sensation of gasping or choking? | ___yes (3 pts) | ___no |
| 4. Do you often wake up with a dry mouth? | ___yes (2 pts) | ___no |
| 5. Do you find your sleep to be non-refreshing? | ___yes (2 pts) | ___no |
| 6. During your waking time, do you often feel tired, fatigued, or not up to par? | ___yes (1 pt) | ___no |
| 7. Do you fall asleep in any situations where you did not intend to? | ___yes (1 pt) | ___no |
| 8. Do you have (or are being treated for) high blood pressure and/or diabetes? | ___yes (1 pt) | ___no |

Total points _____

Please add up the number of questions that were answered “yes.” If the number of questions answered “yes” is greater than 2, the patient is a candidate for a diagnostic sleep study.

- 0 – 2 points = Lower risk of having Obstructive Sleep Apnea
- 3 – 6 points = Moderate risk of having Obstructive Sleep Apnea
- 7 - 15 points = High risk of having Obstructive Sleep Apnea



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INSURANCE, BILLING & FINANCIAL POLICIES

I, _____, have been informed by TMJ & Sleep Therapy Centre of the South Shore and acknowledge that:

- TMJ & Sleep Therapy Centre of the South Shore does not participate in any medical or dental plans and are NOT in-network providers in any medical or dental plans.
- Insurance is a method of reimbursing a patient for fees paid to the doctor. The receipt provided or super - bill contains all the dates, special codes, and charges required by most insurance companies. Attach this receipt/super bill to any insurance form you are filing. It acts as the doctor's portion of the claim.
- I fully accept financial responsibility for payment for all diagnostic and treatment services TMJ & Sleep Therapy Centre of the South Shore doctors render in our offices.
- I understand that insurance policy limits do not apply to the services provided by the doctors in this office.
- I fully understand that TMJ & Sleep Therapy Centre of the South Shore will not be filing with my insurance company seeking reimbursement for services rendered.

CANCELLATION POLICY / NOT KEEPING YOUR APPOINTMENT

All patients will be charged a fee of \$300 for appointments not cancelled within 24 hours prior to the date of the appointment. All appointments scheduled on a Monday must be cancelled by 2pm on the Friday prior to your appointment.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

Name: _____

Signature: _____

Date: _____



NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is issued. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests

to receive confidential communications of protected health information from us by alternative means or at alternative locations.

Acknowledgment:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Private Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____



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AUTHORIZATION FOR LIMITED RELEASE OF PHI TO RELATIVE OR OTHER DESIGNATED INDIVIDUALS

I, _____, understand that under the new HIPAA Privacy Act, TMJ & Sleep Therapy Centre of the South Shore will only release my Protected Health Information to me, or, only that information that TMJ & Sleep Therapy Centre of the South Shore deems necessary to promote my proper healthcare management, to the individual or individuals that I have designated below. I understand that I must inform the office if I wish to amend or change this authorization.

_____relationship _____

_____relationship _____

_____relationship _____

_____relationship _____

Signature _____ Date _____

HIPAA II