TMJ & Sleep Solutions
Mark J. Barnes, DDS

Patient Name_____
FIRST MI LAST

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

Whom may we thank for your referral? _____

What can we help you with? _____

_____

Street Address: _____City: _____ State: ____ Zip: _____

Home #: _____Work #: _____Cell #_____

☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Other_____

E-mail 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.)

Insurance Information: *We will gladly submit your insurance claim and any necessary information at each visit, as a service. It is your responsibility to follow up with your insurance company for payment. Please let us know if you have any questions.*

Please bring insurance cards to your appointment(s).

Insured's name:_____
Employer's name:_____
Insured's date of birth:_____

Consent and Release of Information

I authorize the release of a full report of examination findings, diagnoses, treatment program, etc. to any referring or treating dentist or physician. I authorize Dr. Mark Barnes, D.D.S., PC and/or his associates to release any 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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What Are Your Rights?

You have the right to:

- Request restrictions on certain uses and disclosures of your health information.
- Request that our office communicate your health information privately, with no other family members present or through mailed communications that are sealed and labeled.
- To read and read and review any an all copies of your health information including your complete chart, x-rays, and billing records. There will be a reasonable fee for duplication of your records.
- Ask us to update or modify your records if you believe that your health information records are incomplete or incorrect. There must be a reasonable reason for this change and our office reserves the right to deny this request if the records in question are not created by our office or are inaccurate.
- Request a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations. Please limit these requests to no more than six years at a time. There may be a reasonable charge for these duplications.
- To obtain a copy of these privacy notices directly from our office at any time.
- To express complaints to us or the Secretary of Health and Human Services if you believe that your privacy rights have been compromised. We encourage you to express any concerns that you may have. Thank you for communicating your complaints in writing.

We are required by law to maintain the privacy of your health information and provide you and/or your representative this notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If there is a change, we will be sure that each patient receives a copy of the revised Notice. By signing below, I give the TMJ and Sleep Solutions permission to use the contact information I have provided to confirm appointments and contact me via phone, e-mail, or USPS.

Patient Acknowledgement

Patient Name(s)_____

Thank you very much for taking the time to review our procedures in protecting your private health information. If you have any questions, please feel free to ask any member of the staff in our office. Please sign and return this form to acknowledge your understanding of the information.
Thank you!

Signature: _____
*Date:*_____

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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?_____Why?_____

LIST ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:
_____
_____
_____

PAST MEDICAL HISTORY:

- ☐ Acid reflux/GERD
- ☐ AIDS/HIV
- ☐ Artificial joints (hip, knee)
- ☐ Asthma
- ☐ Autoimmune disorders
- ☐ Blood pressure (high or low)
- ☐ Bleeding disorders
- ☐ Cancer/chemotherapy
- ☐ Chemical addictions/Treatment
- ☐ High cholesterol
- ☐ Chronic fatigue/fibromyalgia
- ☐ Cosmetic surgery
- ☐ Depression/anxiety
- ☐ Diabetes/blood sugar
- ☐ Difficulty sleeping
- ☐ Glaucoma/eye problems
- ☐ Head injury/concussion
- ☐ Headaches
- ☐ Heart disease/heart condition
- ☐ Hepatitis
- ☐ Herpes/STD
- ☐ Injury to face or neck
- ☐ Intestinal disorders
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung conditions
- ☐ Medical marijuana use
- ☐ Migraines
- ☐ Neck/back/spine conditions
- ☐ Neuralgia
- ☐ Chronic sinusitis
- ☐ Nasal drainage
- ☐ Night sweats/nightmares
- ☐ Osteoarthritis
- ☐ Osteoporosis (Fosamax, etc.)
- ☐ Pacemaker
- ☐ Prostate disease
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Sleep apnea/snoring
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight loss medication (Fen-Phen)
- ☐ Difficulty breathing through nose
- ☐ Other: Use back of form

MEDICATIONS/SUPPLEMENTS:
_____
_____
_____
_____

PAST SURGICAL HISTORY:
_____
_____
_____

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SOCIAL HISTORY: Marital status:_____ Occupation:_____

- ☐ Nonsmoker (never smoked)
- ☐ Ex-smoker
- ☐ Current smoker –How many packs per day? _____

Alcohol consumption:

- ☐ Never
- ☐ Occasional
- ☐ Frequent

FAMILY HISTORY: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your children: _____

REVIEW OF SYSTEMS:

Constitutional:	☐ Weight loss ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats
Eyes:	☐ Blurry vision ☐ Eye pain ☐ Eye discharge
ENT:	☐ Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Congestion ☐ Tinnitus ☐ Sinus problems
Cardiovascular:	☐ Chest pain ☐ Palpitations ☐ Rapid heart rate
Respiratory:	☐ Shortness of breath ☐ Chronic cough
Gastrointestinal:	☐ Nausea ☐ Vomiting ☐ Frequent heartburn ☐ Trouble swallowing
Skin:	☐ Skin sore or ulcers ☐ Mole changes
Musculoskeletal:	☐ Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Joint swelling ☐ Back pain
Psychiatric:	☐ Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Panic attacks ☐ Use of antidepressants
Endocrine:	☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Excess sweating
Neurological:	☐ Seizures ☐ Migraines ☐ Numbness ☐ Dizziness/vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke
Hem/Lymphatic:	☐ Swollen lymph node ☐ Prolonged bleeding ☐ Blood clots
Allergic/Immune:	☐ Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive

DENTAL HISTORY:

Your most recent dentist: _____Date of last dental visit: _____

Do you have dental concerns now? _____

Have you had: (Check all that apply)

☐ Orthodontics (braces) ☐ Implants ☐ Splint/nightguard ☐ Jaw surgery ☐ Periodontal disease (gum disease) ☐ Unusual oral issues/procedures/complications

☐ Problems keeping mouth open

Bite/Jaw Concerns:

☐ Mismatched bite ☐ Hard to relax jaw ☐ Uncomfortable bite ☐ Teeth chipped or worn down ☐ Clenching ☐ Grinding ☐ Difficulty breathing through nose ☐ Trouble swallowing

Other: _____

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Trauma History:
Have you ever been involved in an automobile accident or had other trauma (horses, recreational injury, bike, etc.)?
_____
_____

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

Please use the back of this form for any additional information if necessary.

_____
Signature of Reviewing Physician Date

_____
Signature of Patient Date

Clinician Name
Address

TMJ SCALE™

ADA ACCEPTED American Dental Association

Pain Resource Center

This questionnaire is designed to help your doctor evaluate your problem. Please answer all questions as honestly as possible. Use a **dark #2 lead pencil**. Mark answers clearly, erasing completely any changes. Make no marks outside answer spaces. **Do not skip any questions**, even if you are not absolutely sure. (Marking Example: [ ] [■])

Initials: ___ ___ ___ Last Six Numbers of Social Security No. ___ ___ - ___ ___ ___ ___

Today's Date ___/___/___ Age _____ Sex (mark one) [1] Male [2] Female

Marital Status (mark one): [1] Single [2] Married [3] Separated [4] Divorced [5] Widowed [6] Remarried

Ethnic/Racial Group (mark one): [1] Black [2] Hispanic [3] Oriental [4] White [5] Other

Number of School Years (mark one): [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20+]

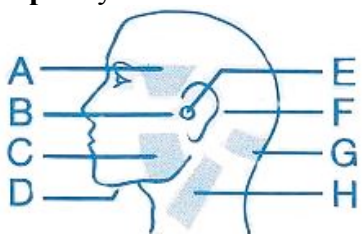
Problem Length (mark one): [1] None [2] Less Than 1 Month [3] 1-5 Months [4] 6-11 Months [5] 1-2 Years [6] 3-5 Years [7] 6-10 Years [8] 10+ Years

1. This question should only be answered if you have upper and lower front teeth or are wearing a replacement for them. Open your mouth as wide as possible and position your hand as shown in the diagram below. Place as many fingers as possible between your upper and lower front teeth. Now **mark one number** below indicating the **number of fingers.**

(mark one)

less than 1 finger…… [0]
at least 1 finger…… [1]
at least 2 fingers…… [2]
at least 3 fingers…… [3]
at least 4 fingers…… [4]

For questions #2-8 below, locate each area on your face (except F) using the lettered diagram. Press each area firmly on both sides of your face. **Mark the number** that indicates the **maximum amount of pain** you feel.



no pain 0
slight pain 1
moderate pain 2
quite a bit of pain 3
extreme pain 4

(mark one)

2. Pressing my temples (A on diagram)…….... [0] [1] [2] [3] [4]
3. Pressing my jaw joints (B on diagram)…… [0] [1] [2] [3] [4]
4. Pressing my jaw muscles (C on diagram)…… [0] [1] [2] [3] [4]
5. Pressing the muscles under the sides of my jaw (D on diagram)……. [0] [1] [2] [3] [4]
6. Pressing in my ears (E on diagram)……..... [0] [1] [2] [3] [4]
7. Pressing the back of my neck (G on diagram)……. [0] [1] [2] [3] [4]
8. Pressing the sides of my neck(H on diagram)…….. [0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

		(mark one)
9.	Just a light touch on my face causes shock-like pain……..	[0] [1] [2] [3] [4]
10.	My jaw must click or pop before I can open it wide……	[0] [1] [2] [3] [4]
11.	My jaw opens all the way without any sideways movements……..	[0] [1] [2] [3] [4]
12.	My jaw locks open……..	[0] [1] [2] [3] [4]
13.	I have headaches which begin after seeing flashes of light or dark spots……	[0] [1] [2] [3] [4]
14.	My jaw moves easily……	[0] [1] [2] [3] [4]
15.	I have health problems which haven't responded to treatment…….....	[0] [1] [2] [3] [4]
16.	I have pain in my jaw joint(s) (B on the diagram)……..	[0] [1] [2] [3] [4]
17.	My jaw tires easily when chewing……..	[0] [1] [2] [3] [4]
18.	I have headaches which are made worse by bright light…….....	[0] [1] [2] [3] [4]
19.	It hurts my teeth when I bite…….	[0] [1] [2] [3] [4]
20.	I have muscle or joint pain in areas other than my head or neck…….	[0] [1] [2] [3] [4]
21.	I can move my jaw more to one side than the other…….	[0] [1] [2] [3] [4]
22.	I feel tense and worried……	[0] [1] [2] [3] [4]
23.	I have drainage from my ear(s)……	[0] [1] [2] [3] [4]
24.	I feel sad and depressed……	[0] [1] [2] [3] [4]
25.	I clench my teeth……..	[0] [1] [2] [3] [4]
26.	My bite feels comfortable……	[0] [1] [2] [3] [4]
27.	I have jaw pain which gets worse the more I move my jaw……	[0] [1] [2] [3] [4]
28.	It is difficult to find a comfortable position for my jaw……..	[0] [1] [2] [3] [4]
29.	I have pain in my ear(s) (E on diagram)……..	[0] [1] [2] [3] [4]
30.	I have sinus problems……..	[0] [1] [2] [3] [4]
31.	When I bite down normally, my front teeth touch……..	[0] [1] [2] [3] [4]
32.	During my life, I've had many different painful disorders……..	[0] [1] [2] [3] [4]
33.	I have facial pain which comes on suddenly like electric shocks……	[0] [1] [2] [3] [4]
34.	I can open my mouth as far as possible without pain……..	[0] [1] [2] [3] [4]
35.	I have pain in or behind my eye(s)……..	[0] [1] [2] [3] [4]
36.	My jaw makes a grating or grinding noise when it opens and closes……..	[0] [1] [2] [3] [4]
37.	I think my bite is off…….	[0] [1] [2] [3] [4]
38.	I have pain which gets worse with stress or tension……	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

(mark one)

39.	My jaw clicks or pops when I chew…….	[0] [1] [2] [3] [4]
40.	I can bite down hard without pain in my jaw……...	[0] [1] [2] [3] [4]
41.	One painful problem is followed by another……	[0] [1] [2] [3] [4]
42.	I have jaw pain which makes me feel sick and feverish……..	[0] [1] [2] [3] [4]
43.	I grind my teeth during the day……	[0] [1] [2] [3] [4]
44.	I have numb areas on my face……..	[0] [1] [2] [3] [4]
45.	I use nerve pills, sleeping pills, or alcohol for relief……	[0] [1] [2] [3] [4]
46.	I can move my jaw smoothly……...	[0] [1] [2] [3] [4]
47.	I can chew without bumping my teeth unexpectedly……...	[0] [1] [2] [3] [4]
48.	I have a feeling of pins and needles on my face……...	[0] [1] [2] [3] [4]
49.	I have pain in my jaw muscles (C on diagram)……	[0] [1] [2] [3] [4]
50.	I have pain in the back of my neck (G on diagram)…….	[0] [1] [2] [3] [4]
51.	Over the years, I've been under a lot of stress……..	[0] [1] [2] [3] [4]
52.	My jaw twitches or jerks uncontrollably……..	[0] [1] [2] [3] [4]
53.	When I bite down normally, my back teeth touch……...	[0] [1] [2] [3] [4]
54.	The way my front teeth fit seems to be changing……	[0] [1] [2] [3] [4]
55.	A light touch on one side of my face causes shock-like pain on the other…..	[0] [1] [2] [3] [4]
56.	I have a ringing in my ear(s)……	[0] [1] [2] [3] [4]
57.	I have pain which gets worse with certain people or situations……...	[0] [1] [2] [3] [4]
58.	I have pain in the side(s) of my neck (H on diagram)……..	[0] [1] [2] [3] [4]
59.	I have a steady pain across my forehead……..	[0] [1] [2] [3] [4]
60.	I have many changing pains…….	[0] [1] [2] [3] [4]
61.	I feel angry……...	[0] [1] [2] [3] [4]
62.	Other people notice noise from my jaw when I chew……..	[0] [1] [2] [3] [4]
63.	I can chew food as well as I used to…….	[0] [1] [2] [3] [4]
64.	I have health problems which seem to be getting worse……..	[0] [1] [2] [3] [4]
65.	I have pain in the muscles under my jaw (D on diagram)……	[0] [1] [2] [3] [4]
66.	I have pain in my temple(s) (A on diagram)……	[0] [1] [2] [3] [4]
67.	I feel anxious……	[0] [1] [2] [3] [4]
68.	I can open my mouth as wide as I used to……	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

		(mark one)
69.	The way my back teeth fit seems to be changing……	[0] [1] [2] [3] [4]
70.	I sleep well……..	[0] [1] [2] [3] [4]
71.	I have head or facial pain which gets worse when I bend over……	[0] [1] [2] [3] [4]
72.	When I touch one side of my face, the other side gets numb……..	[0] [1] [2] [3] [4]
73.	My jaw gets stuck and won't open all the way…….	[0] [1] [2] [3] [4]
74.	The only real problems in my life are problems with my physical health…...	[0] [1] [2] [3] [4]
75.	I've had conflicting doctors' opinions about health problems……..	[0] [1] [2] [3] [4]
76.	I can move my jaw in any direction without pain……	[0] [1] [2] [3] [4]
77.	I have facial pain which gets worse in cold weather……	[0] [1] [2] [3] [4]
78.	I feel frustrated…….	[0] [1] [2] [3] [4]
79.	I have a stuffy nose……..	[0] [1] [2] [3] [4]
80.	Recently I've been under a lot of stress……	[0] [1] [2] [3] [4]
81.	I have headaches which make me feel sick to my stomach…….	[0] [1] [2] [3] [4]
82.	I can take big bites of things like apples……..	[0] [1] [2] [3] [4]
83.	I have work or family pressures……..	[0] [1] [2] [3] [4]
84.	I have pain and stiffness in my finger joints……	[0] [1] [2] [3] [4]
85.	My back teeth feel like they fit properly……..	[0] [1] [2] [3] [4]
86.	I believe I have an incurable problem in spite of reassurance by doctors……	[0] [1] [2] [3] [4]
87.	In the morning my teeth are sore and my jaw is tired……..	[0] [1] [2] [3] [4]
88.	My ears feel blocked or stopped up……....	[0] [1] [2] [3] [4]
89.	I have many health problems……..	[0] [1] [2] [3] [4]
90.	My jaw moves just as far forward as it used to……	[0] [1] [2] [3] [4]
91.	I have difficulty swallowing…….	[0] [1] [2] [3] [4]
92.	I have pain behind my ear(s) (F on diagram)……..	[0] [1] [2] [3] [4]
93.	I have facial pain when other joints are also sore……	[0] [1] [2] [3] [4]
94.	I have nervous problems……..	[0] [1] [2] [3] [4]
95.	I have throbbing headaches……..	[0] [1] [2] [3] [4]
96.	I feel dizzy……	[0] [1] [2] [3] [4]
97.	I consider myself to be a sickly person……	[0] [1] [2] [3] [4]