TIME 09:23 AM DATE 6/19/2017

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Other Parent`s Name

Other Parent`s #

Physician Name

Chief Complaint

Last Dental Visit

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

ADVANCED
DENTAL ARTS NW
Russell C. Teasdale DMD

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Primary Care Physician and date of last physical _____

Have you ever been hospitalized or had a major operation? □Yes □No _____

Have you ever had a serious head or neck injury? □Yes □No _____

Are you taking any medications, pills, or drugs? □Yes □No _____

Do you take, or have you taken, Phen-Fen or Redux? □Yes □No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphonates? □Yes □No _____

Have you ever had Botox or Dermal Fillers? □Yes □No _____

Have you ever had any other elective facial cosmetic procedures and/or laser treatments? □Yes □No _____

Have you ever been diagnosed with Sleep Apnea or had a Sleep Study or testing done? □Yes □No _____

Have you ever had Orthodontic treatment? Type, Length of treatment, How long ago? □Yes □No _____

Are you on a special diet? □Yes □No _____

Do you use tobacco? □Yes □No

Women: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking Oral contraceptives

Are you allergic to any of the following?

□ Aspirin/Ibuprofen □ Penicillin □ Codeine □ Acrylic
□ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV positive □Yes □No	Cortisone Medicine □Yes □No	Hemophilia □Yes □No	Radiation Treatments □Yes □No
Alzheimer's Disease □Yes □No	Diabetes □Yes □No	Hepatitis A □Yes □No	Recent Weight Loss □Yes □No
Anaphylaxis □Yes □No	Drug Addiction □Yes □No	Hepatitis B or C □Yes □No	Renal Dialysis □Yes □No
Anemia □Yes □No	Easily Winded □Yes □No	Herpes □Yes □No	Rheumatic Fever □Yes □No
Angina □Yes □No	Emphysema □Yes □No	High Blood Pressure □Yes □No	Rheumatism □Yes □No
Arthritis/ Gout □Yes □No	Epilepsy/ Seizures □Yes □No	High Cholesterol □Yes □No	Scarlet Fever □Yes □No
Artificial Heart Valve □Yes □No	Excessive Bleeding □Yes □No	Hives or Rash □Yes □No	Shingles □Yes □No
Artificial Joint □Yes □No	Excessive Thirst □Yes □No	Hypoglycemia □Yes □No	Sickle Cell Disease □Yes □No
Asthma □Yes □No	Fainting Spells/ Dizziness □Yes □No	Irregular Heartbeat □Yes □No	Sinus Trouble □Yes □No
Blood Disease □Yes □No	Frequent Cough □Yes □No	Kidney Problems □Yes □No	Spina Bifida □Yes □No
Blood Transfusion □Yes □No	Frequent Diarrhea □Yes □No	Leukemia □Yes □No	Stomach/ Intestinal Disease □Yes □No
Breathing Problems □Yes □No	Frequent Headaches □Yes □No	Liver Disease □Yes □No	Stroke □Yes □No
Bruise Easily □Yes □No	Genital Herpes □Yes □No	Low Blood Pressure □Yes □No	Swelling of Limbs □Yes □No
Cancer □Yes □No	Glaucoma □Yes □No	Lung Disease □Yes □No	Thyroid Disease □Yes □No
Chemotherapy □Yes □No	Hay Fever □Yes □No	Mitral Valve Prolapse □Yes □No	Tonsillitis □Yes □No
Chest Pains □Yes □No	Heart Attack/ Failure □Yes □No	Osteoporosis □Yes □No	Tuberculosis □Yes □No
Cold Sores/ Fever Blisters □Yes □No	Heart Murmur □Yes □No	Pain in Jaw joints □Yes □No	Tumors or Growths □Yes □No
Congenital Heart Disorder □Yes □No	Heart Pacemaker □Yes □No	Parathyroid Disease □Yes □No	Ulcers □Yes □No
Convulsions □Yes □No	Heart Trouble/ Disease □Yes □No	Psychiatric Care □Yes □No	Venereal Disease □Yes □No

Patient Signature _____ Date _____

Please read through and answer the following:

How often do you brush? _____ Do you use a manual or electric toothbrush? _____

How often are you flossing? _____ Do you use a mouth rinse? _____

On a scale from 1 – 10 (1 being the worst and 10 the best), how do you rate your home care? _____

Last dental examination: _____ Last dental cleaning: _____

Chief complaint or main reason for dental visit today:

New Patient Cleaning Broken Tooth (area: UR UL LL LR) Consult: _____

Other: _____

Please circle the following that apply to you:

HEAD

Frequent headaches	Migraines	Tension Headaches
Fatigue/fogginess	Tinnitus	Dizziness/ Vertigo

NECK/BACK

Upper back pain	Fibromyalgia	Joint pain
Limited range of motion	Muscle Atrophy	Muscle pain

THROAT

Difficulty breathing through nose	Choking/shortness of breath	Snoring/ Breathe loud

JAW

Jaw/TMJ Pain	Jaw Popping/Clicking	Clenching/Grinding
Locked In/Restricted bite	Jaw/chin too strong/weak	Limited jaw movement

MOUTH

Gummy smile	Small lips	Large nasolabial folds
Too broad smile	Too Narrow smile	Chronic bad breath

GUMS

Bleeding after brushing	Bleeding after flossing	Black triangles
Receding gums	Swollen/ puffy	Sore/ hurt

TEETH

Yellow/ Dark teeth	Spaces or Gaps/ Pack food	Crooked/ Uneven
Notching near gums	Sensitive to hot/cold	Too Short/ Worn down
Misshapen/ Not centered	Buck teeth/ Stick out	Too Long/ Horsey teeth
Missing teeth	Concerned about silver fillings	Discoloration/Calcification

ADVANCED
DENTAL ARTS NW
Russell C. Teasdale DMD

FINANCIAL POLICY AND AGREEMENT

Few things affect the quality of life as much as the comfort and confidence of comprehensive dental care. At ADANW, we are confident we provide a great value for our patients, providing personalized and high quality and high tech services, not only from Dr. Teasdale, but also from every member of our team. And although we will work with you always to obtain your greatest benefit from your dental insurance, or HSA/FSA accounts, we are not a financial institution and cannot guarantee insurance benefits and insurance payments. We appreciate that people have differing needs in fulfilling their financial obligations, and to help out, we offer the following payment options:

WE REQUIRE PAYMENT IN FULL ON DATE OF SERVICE FOR DENTAL TREATMENT. We can extend a 5% courtesy savings for payment in full by cash or check, for services of $500 or more.

WE ACCEPT: American Express, Discover, Master Card, Visa, Care Credit, Cash, and Check.

PRE-PAYMENT PLAN: Much like a Lay-Away Plan, we accept whatever payments you feel comfortable with, and can begin treatment as soon as it is fully funded.

CARE CREDIT PAYMENT OPTIONS: If you are not able to pay in full on the date of service, then we can assist you in applying for the Care Credit payment option. It does require pre-approval, and has a great, **same as cash, no interest financing option** available. No Additional "payment in full" discounts apply when using Care Credit. We offer 6 month with 0% interest for amounts over $200. 12 month with 0% is only offered for Invisalign and Orthodontic services.

FOR SERVICES OVER $2000: For services in excess of $2000, we request **half paid prior** to the appointment, to reserve time for you. All this will apply 100% toward your final bill. Balance will be due at the time of service.

PATIENTS WITH DENTAL INSURANCE: We welcome your dental insurance if it is an "open option", and we will work with you to obtain your full benefit for our services. Please understand that you, through your employer, have a contract with that insurance carrier, and ADANW is not a party to that agreement. As such, it is not possible to predict *exactly* what each policy pays, although we always strive to be accurate. Because of this, it is important that you recognize that you are ultimately responsible for the full balance, and we will issue you a refund check once the insurance has assisted you with their final payment.

ADANW RESERVES THE RIGHT TO THE FOLLOWING: We can charge $35 for any returned checks. If a patient changes their mind about treatment, we will charge for any incurred lab fees and any doctor chair time. Refunds are done once a month. If a patient chooses to leave the practice, we will forward a copy of your dental records to you or to your new dentist upon receiving your signed, written request.

48 HOUR CANCELLATION AND NO SHOW: ADANW does call, text, and email to confirm your appointment. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $50 per 60 minutes of scheduled time for a broken appointment or cancellation with 2 business days' notice for your appointment. If you have no shown/or last minute cancelled more than 2 times this will result in a non-refundable deposit for the appointment of $50 per 60 minutes.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AND AGREEMENT

Signature Date

ADVANCED
DENTAL ARTS NW
Russell C. Teasdale DMD

Photo and Model Release Letter

At ADANW we like to document all types of services we do here. New patient exams start with a series of photographs for a baseline record that we can always refer back to. When coming in for treatment we like to take before and after photos to show you and to add to your records.

For valuable consideration received, I, _____ hereby give Dr. Russell Teasdale the absolute and irrevocable right and permission, with respect to the photographs that have been taken of me to be used in the following ways and republished for any commercial use for the territory of the whole world: (please choose the following)

- ☐ **Intraoral Only (inside the mouth, usually before and afters of filling or crowns replacements)**
- ☐ **Extraoral Only (full face photos, usually for full mouth reconstructions)**
- ☐ **Both (intraoral and extraoral photos)**

A. To copyright the same in its own name or any other name that Dr. Russell Teasdale may choose.
B. To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not by the way of limitation) illustration, promotion and advertising and trade through December 31, 2099.

This authorization and release shall also apply to the benefit of the legal representatives, licensees and assigns of Dr. Russell Teasdale and Advanced Dental Arts NW.

I am over the age of eighteen. I have read the foregoing and fully understand the terms of this release.

- ☐ **None of the Above, Please do not use any of my photos for "Before and After" photos.**

Signed: _____ Date: _____

ADVANCED DENTAL ARTS NW

1316 SW 13TH AVENUE

PORTAND, OR 97201

(503) 235-0555

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of this office.

SIGNATURE

Please Note: It is your right to refuse to sign this acknowledgement.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

ADVANCED DENTAL ARTS NW

RUSSELL C. TEASDALE, D.M.D.

1316 SW 13TH AVENUE, PORTLAND, OR 97201
(503) 235-0555

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

You can authorize ADANW to discuss information to certain individuals. This gives us permission to discuss any insurance and account related issues as well as taking payments from partners and spouses.

Name and Relationship of Authorized Persons:

_____

_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name & Relationship*

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Advanced Dental Arts NW

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09/23/13), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ 25 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Russell Teasdale

Telephone: 503-235-0555 Fax: 503-224-5726

E-mail: adanw@advanceddentalartsnw.com

Address: 1316 SW 13th Ave., Portland, Oregon 97201

ADVANCED DENTAL ARTS NW

RECORDS RELEASE REQUEST

To Releasing Doctor or Physician: _____

Doctor Address: _____

Phone: _____ or Fax: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Advanced Dental Arts NW
Dr. Russell C. Teasdale, DMD
1316 SW 13th Avenue ● Portland, Oregon 97201
P: 503-235-0555 ●F: 503-224-5726

Please email to: adanw@advanceddentalartsnw.com

Please send most current:

□ FMX or PANO Date: _____

□ BWX Date: _____

□ Perio Charting Date: _____

□ Any information pertaining to tooth # _____

□ Other _____

Last Dental Visit _____ Last Hygiene Visit _____

_____

Patient First and Last Name Date of Birth

_____

Patient or Responsible Party Signature Date

DTR/FDH Scaling Form Patient:_____ Date:_____

A) Tooth Sensitivity Pain Scale

Office Use:

With EMG *W/O EMG*

preop *postop*

Canine Rise #'s _____

Rate your tooth sensitivity pain on a scale from 0 to 10:

0 no pain whatsoever
1 I almost never feel it
3 I'm aware of it several times a week
5 pain that just barely needs store bought medication
7 I really should see my dentist
9 I must have stronger medication and need to see my dentist today!
10 THE worst possible pain!

Please describe your tooth sensitivity pain to a ***5 second ice water swish***:

No Pain **Very Painful**

0 1 2 3 4 5 6 7 8 9 10

B) Occlusion/Bite Related Questions

Do you: PLEASE CIRCLE THE NUMBER IF YES :

1- drink cold drinks through a straw to prevent a painful response in your teeth?
2- experience that tooth sensitivity pain dissipates rapidly?
3- have trouble eating crunchy or chewy foods?
4- have trouble drinking a cold drink or eating ice cream?
5- experience pain in your teeth when breathing in cold air that dissipates when you close your mouth and breathe through your nose?
6- experience a transient sensitivity pain in several of your teeth or a general area?
7- feel that your jaw and cheek muscles are often tight?
8- notice that chewing gum or chewy foods makes your jaw tired?
9- clench or grind your teeth?
10- notice that you consciously keep your lower teeth from touching your upper teeth because your teeth hurt slightly if not?
11- find yourself sticking your tongue between your front teeth sometimes?

C) Less Related to Occlusion Questions

Do you: PLEASE CIRCLE THE NUMBER IF YES:

12- feel that your tooth sensitivity pain lingers long after the hot or cold stimulus is gone?
13- experience lingering pain after separating your teeth between crunchy foods?
14- feel that cold makes the pain in your tooth or teeth feel better?
15- experience pain in your tooth or teeth that wakes you up at night?
16- notice that you consciously keep your lower teeth from touching your upper teeth because your teeth hurt unbearably if not?
17- find that you must put something between your front teeth or the pain is unbearable?
18- think that you know exactly the one tooth that's causing your pain?
19- feel that you cannot open your jaw as far as you used to?
20- feel that hot drinks are intolerable and lead to a very painful response?

CONTINUED ON BACK

D) Headache/Tension Related Questions (answer if you experience headaches):

Do you: PLEASE CIRCLE THE NUMBER IF YES:

21- have debilitating headaches that require a trip to your physician?
22- have mild headaches that only require over the counter medication?
23- feel that the headaches are new to you?
24- get LIGHT SENSITIVE when you have headaches?
25- get NAUSEOUS when the headaches happen?
26- find that the headaches are IMPACTING your work, school, or recreational activities?
27- find that the headaches are intense and throbbing?
28- get upper neck tension or pain with your headaches?
29- get shoulder tension or with your headaches?
30- ***feel that you have been >50% disabled from your headaches for more than 11 of the last 90 days?***

E) Past Providers/Therapies

Have you seen a **dentist** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen a **Primary Care Doctor** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen an **ENT Specialist** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you seen a **Neurologist** before for these symptoms?
If yes, what treatment was performed and did it work?

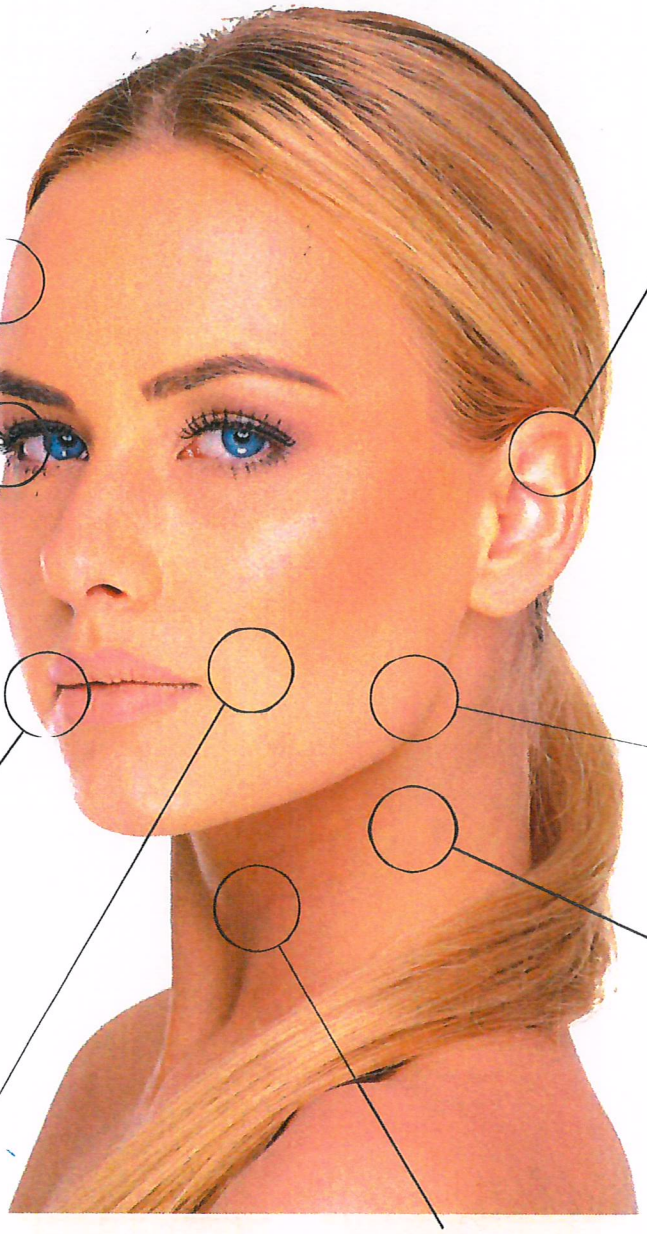
Have you seen a **Chiropractor** before for these symptoms?
If yes, what treatment was performed and did it work?

Have you tried, **Acupuncture Massage Therapist, or Physical Therapist?**

Do you suffer from any of the following?

Circle any symptoms you suffer from

Patient Name: _____ Date: _____



Head Pain, Headache

- Forehead
- Temples
- "Migraine" Type
- Sinus Type
- Shooting Pain Up Back of Head
- Hair and/or Scalp Painful to Touch
- Brain Fog

Eyes

- Pain Behind Eyes
- Bloodshot Eyes
- May Bulge Out
- Sensitive to Sunlight
- Weeping Eyes
- Double Vision
- Problems Tracking While reading
- Eye Muscle Twitching

Mouth

- Discomfort
- Limited Opening of Mouth
- Inability to Open Smoothly
- Jaw Deviates to One Side When Opening
- Locks Shut or Open
- Can't Find bite

Teeth

- Clenching, Grinding at Night
- Looseness and Soreness of Back Teeth
- Tooth Sensitivity to Cold or Ice

Ear Problems

- Hissing, Buzzing or Ringing
- Decreased Hearing
- Ear Pain, Ear Ache, No Infection
- Clogged, "Itchy" ears
- Vertigo, Dizziness

Jaw Problems

- Clicking, Popping Jaw Joints
- Grating Sounds
- Pain in Cheek Muscles
- Uncontrollable Jaw and/or Tongue Movements

Neck Problems

- Lack of Mobility, Stiffness
- Neck Pain
- Tired, Sore Muscles
- Shoulder Aches and Back Aches
- Arm and Finger Numbness and/or Pain

Throat

- Swallowing Difficulties
- Laryngitis
- Sore Throat With No Infection
- Voice Irregularities or Changes
- Frequent Coughing or Constant Clearing of Throat
- Feeling of Foreign Object in throat Constantly
- Feeling of "hand resting on throat"