Arkansas TMJ Center

W. Brent Larsen, D.D.S.
General Dentist

Diagnosis & Treatment of TMJ
Neuromuscular Disorders

Name_____ Appointment Date_____

Time_____

Comprehensive Exam, Study Models and Photographs $_____

OUR POLICY CONCERNING INSURANCE

As a courtesy to our patients, our office will file the necessary insurance forms with your MEDICAL insurance carrier due to the fact these are medical procedures, **NOT** dental. We file all medical insurances except **MEDICARE AND TRICARE.**

Your insurance contract is between you and your insurance company. However, our professional services are rendered to you, not the insurance company. Therefore, you are directly responsible to us for the payment of treatment. **This is to be paid when the treatment is performed**. The insurance company can then reimburse you directly.

Only in this manner can we achieve the best interpersonal relationship and optimal treatment demanded. Our fees for services are the same for all patients, whether or not they have an insurance plan. We feel strongly that all patients deserve from us the very best care we can provide. Furthermore, we feel everyone benefits when definite arrangements are agreed upon, prior to the beginning of the treatment.

Due to the length of time reserved for your appointment, you must give our office at least 24 hours notice of cancellation or there will be a charge. Please feel free to call us at (501) 660-7881 if you have any questions concerning our office policy.

PLEASE FILL OUT THE ATTACHED HEALTH HISTORY AND RETURN AT YOUR APPOINTED TIME.

2501 Crestwood Drive, Suite 301
North Little Rock, Arkansas 72116
(501) 660-7881 * (501) 660-7899 Fax

ARKANSAS TMJ CENTER

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Please fill out the following information. This information is important for our records and your health.

Date: _____

Patients Name: Last _____ First _____ Middle Initial _____

Date of Birth: _____ Age: _____ Sex: Male _____ Female _____

Parent's Name (if Minor): _____

Home Address: _____

City: _____ State: _____ Zip Code:_____

How long at this address? _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Best number to call: _____

Employed by: _____ How long? _____

Business Address: _____

City: _____ State: _____ Zip Code:_____

Occupation: _____ Social Security#: _____

Single: _____ Married: _____ Widowed: _____ Separated: _____ Divorced: _____

Name of Spouse: _____ Employed by: _____

Person responsible for payment of account: _____

Primary Insurance Company: _____

Membership Plan Number: _____

Are you currently involved in any litigation related to this condition? Yes _____ or No _____

If yes, name, address, and phone number of the attorney _____

_____

_____

List specific complaints in order of severity:

1: _____ 2: _____ 3: _____

4: _____ 5: _____ 6: _____

When did you first experience the problem for which you are seeking help? _____

Did any of the symptom(s) start after any of the following actions?

_____ Large bite/Yawn _____ Chewing Food _____ 3rd Molar Extraction

_____ Cervical traction _____ Emotional Upset _____ Dental Treatment

Injury: _____ to head _____ to neck _____ to jaw _____ to back _____ others

Whom may we thank for referring you to our office? _____

Date of last MEDICAL EXAM: _____

Family Physician: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Other Physicians or Dentist you have seen concerning this condition: _____

_____

Height: _____ Weight: _____

Please check YES or NO and provide details if requested:

Are you currently under medical treatment: _____ Yes _____ No

Do you have heart problems? _____ Yes _____ No

Do you have a pacemaker? _____ Yes _____ No

Have you had Rheumatic Fever: _____ Yes _____ No

If so, when? _____

Do you have High Blood Pressure? _____ Yes _____ No

If so, is it controlled? _____ Yes _____ No

Have you had pain in your chest? _____ Yes _____ No

Do your ankles swell? _____ Yes _____ No

Have you been told you are Anemic? _____ Yes _____ No

Have you had a stroke? _____ Yes _____ No

If so, when? _____

Do you have Diabetes? _____ Yes _____ No

If so, is it controlled? _____ Yes _____ No

Are you subject to Fainting or Dizziness? _____ Yes _____ No

Do you have any Nervous Disorders? _____ Yes _____ No

Do you take Tranquilizers or Sedatives? _____ Yes _____ No

Are you Allergic to any medications? _____ Yes _____ No

If so, what? _____

Do you have Asthma, Hay Fever, or Allergies? _____ Yes _____ No

Have you had Tuberculosis? _____ Yes _____ No

Have you had Infectious Hepatitis? _____ Yes _____ No

If so, when? _____

Do you have Arthritis? _____ Yes _____ No

Have you had a Tumor or Cancer? _____ Yes _____ No

Do you become Fatigued easily? _____ Yes _____ No

Do you frequently skip breakfast? _____ Yes _____ No

Do you have frequent headaches? _____ Yes _____ No

Do you have more than one alcoholic drink per day? _____ Yes _____ No

Do you smoke, or use Tobacco? _____ Yes _____ No

Have you ever been in a serious accident? _____ Yes _____ No

If so, when and give the nature of injuries. _____

_____

Date and time of any accident that you feel may be related to your discomfort. Explain: _____

_____

Have you experienced prolonged bleeding from a cut or dental procedure? _____ Yes _____ No

Have you had any significant weight change in the last year? _____ Yes _____ No

_____ pounds Lost _____ pounds Gained

Have you had any major operations? _____ Yes _____ No

If so, when and what was the operation? _____

What do YOU think is the cause of your pain? _____

_____

What aspect of your condition concerns you the most? _____

_____

Do you have any known allergies? _____ Yes _____ No

If yes, list: _____

FOR WOMEN (OPTIONAL)

Are you pregnant? _____ Yes _____ No

If so, expected delivery date: _____

Have you reached Menopause? _____ Yes _____ No

Have you had a Hysterectomy? _____ Yes _____ No

SYMPTOMS CHECK LIST

Please check nay of the following symptoms that apply to your condition. (L = Left, R = Right)

Headaches:

Top of head L _____ R _____

Temples L _____ R _____

Forehead L _____ R _____

Back of Head L _____ R _____

Behind the eyes L _____ R _____

Clicking or Popping L _____ R _____

Grating sound in joint L _____ R _____

Ear congestion L _____ R _____

Pain in neck L _____ R _____

Pain in shoulder L _____ R _____

Pain in jaw joint L _____ R _____

Pain in ear L _____ R _____

Facial Pain L _____ R _____

Vertigo (dizziness) L _____ R _____

Tinnitus (ringing in ears) L _____ R _____

Partial inability to open your mouth _____ Yes _____ No

_____ Constant _____ Sporadic

Difficulty swallowing _____ Yes _____ No

Difficulty chewing _____ Yes _____ No

Difficulty breathing through nose _____ Yes _____ No

Face muscle twitch _____ Yes _____ No

OCCLUSAL HABITS:

_____ Clenching ____ AM _____ PM

_____ Teeth hitting in the front first

_____ Gum Chewing

_____ Bruxing ____ AM _____ PM

_____ Cheek biting

_____ Pipe Smoking

_____ Others _____

POSTURAL HABITS:

_____ Phone Cradling

_____ Shoulder Bag

_____ Leans chin in hands

_____ Heavy Lifting

_____ Others _____

LIST ALL CURRENT MEDICATIONS:

MEDICATION	***DOSAGE***	***CONDITION***

COMMENTSO ANY OTHER RELEVANT INFORMATION: _____

_____

_____

_____

_____

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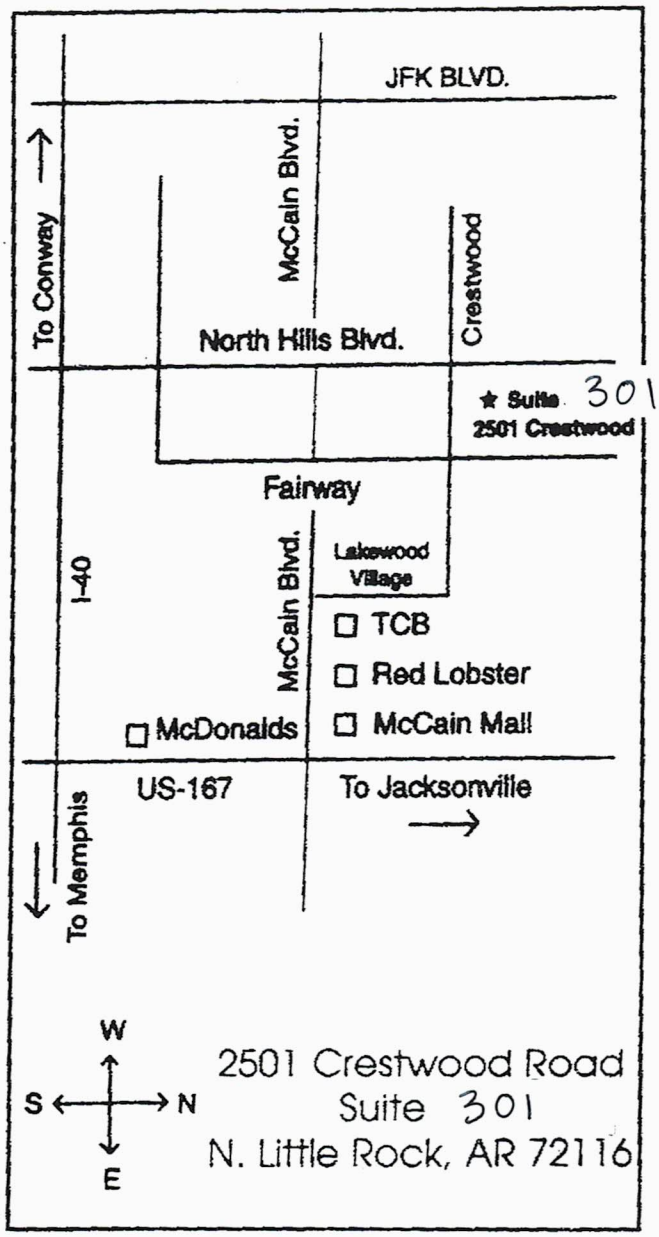
I AUTHORIZE THE RELEASE OF A FULL REPORT OF EXAMINATION FINDINGS, DIAGNOSIS, TREATMENT PROGRAM, ETC., TO ANY REFERRING OR TREATING DENTIST OR PHYSICIAN. I ADDITIONALLY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO INSURANCE COMPAINIES OR FOR LEGAL DOCUMENTATION TO PROCESS CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGADLESS OF INSURANCE COVERAGE.

SIGNED_____ **DATE** _____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