



Advanced Cosmetic & TMJ Treatment Centre

BED PARTNER SURVEY

GIVE TO BED PARTNER

To help us with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for DR. DENTIST to best evaluate your current condition.

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

Patient's Name _____

1. YES NO Do you witness the patient snoring? _____
2. YES NO Do you witness the patient choking or gasping for breath during sleep? _____
3. YES NO Does the patient pause or stop breathing during sleep? _____
4. YES NO Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)? _____
5. YES NO Do you witness the patient clenching and/or grinding his/her teeth during sleep? _____
6. YES NO Does the patient appear refreshed upon waking? _____
7. YES NO Do the patient's sleep habits disturb your sleep? _____
8. YES NO Does the patient sit up in bed, not awake? _____
9. Please check those sleep habits of the patient that are disturbing to you:
 - Snores
 - Restless
 - Wakes up often
 - Loud gasping for breath while sleeping
 - Stops breathing
 - Grinds teeth
 - Becoming very rigid or shaking
 - Biting tongue
 - Kicking during sleep
 - Head rocking or banging
 - Bed-wetting
 - Sleep walking
 - Sleep talking
 - Other _____

Comments: _____

BED PARTNER SURVEY

GIVE TO BED PARTNER

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to daily life in recent times, if these things have not occurred recently, try to work out how they would have affected your partner.

Use the following scale and choose the most appropriate number for each situation:

- | | |
|---|-------------------------------|
| Sitting and reading _____ | 0 = Would never doze |
| Watching TV _____ | |
| Sitting inactive in a public place
(e.g. A theater or a meeting) _____ | 1 = Slight chance of dozing |
| As a passenger in a car for an hour without a
break _____ | 2 = Moderate chance of dozing |
| Lying down to rest in the afternoon when
circumstances permit _____ | 3 = High chance of dozing |
| Sitting and talking to someone _____ | |
| Sitting quietly after a lunch without alcohol _____ | |
| In a car, while stopped for a few minutes in traffic _____ | |

Additional comments regarding the patient's sleep habits not mentioned above:

Please sign and date at the bottom of this form and many thanks for your help.

Partner's Signature _____ Date _____

Dalton Designer Smiles

2415 Prince Street

Conway, AR 72034

(501)327-6453 - Fax: (501) 327-0242

PATIENT INFORMATION

MR MRS DR MS MISS MARRIED SINGLE DIVORCED WIDOWED

PATIENT'S NAME _____

AGE _____ DATE OF BIRTH _____ MALE FEMALE

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE # _____ E-Mail Address _____

HOW LONG AT PRESENT ADDRESS? _____

IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.

PREVIOUS ADDRESS _____

CITY, STATE, ZIP _____

EMPLOYED BY _____

WORK PHONE # _____

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE BOX BELOW

PARENT GUARDIAN NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOW LONG AT PRESENT ADDRESS? _____

SOCIAL SECURITY # _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE INFORMATION We will gladly provide you with an insurance claim form and any necessary information for each visit. It is your responsibility to send your claim to your insurance company and follow up for payment. Please let us know if you have any questions.

INSURANCE COMPANY _____

GROUP NUMBER _____

PHONE NUMBER _____

INSURED'S NAME _____

EMPLOYER NAME _____

INSURED'S DATE OF BIRTH _____

We require payment at the time of service. Our returned check fee is \$50.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES, please explain on the line provided.

MEDICAL HISTORY:

1. YES NO Do you have a current medical problem? _____
2. YES NO Have you been told you have a heart murmur? _____
3. YES NO Do you have any heart problems? What kind? _____
4. YES NO Do you have High or Low Blood Pressure? Is it controlled? YES NO
5. YES NO Have you had rheumatic fever? When _____
6. YES NO Have you had pain in your chest or shortness of breath? _____
7. YES NO Do your ankles swell? _____
8. YES NO Has your physician ever told you that you are anemic? _____
9. YES NO Have you ever had a stroke? When? _____
10. YES NO Have you ever had epilepsy? _____
11. YES NO Do you have diabetes? Is it controlled? _____
12. YES NO Do you have fainting or dizzy spells? _____
13. YES NO Do you feel like your sense of balance has changed? _____
14. YES NO Do you have headaches? How often? Where? _____
15. YES NO Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? _____
16. YES NO Have you been advised not to take any medication? What? _____
17. YES NO Do you have asthma or hay fever? How is it controlled? _____
18. YES NO Have you ever had tuberculosis? When? _____
19. YES NO Have you ever had glaucoma? When? _____
20. YES NO Have you ever had hepatitis? When? _____
21. YES NO Do you have arthritis? How is it controlled? _____
22. YES NO Have you ever had a tumor or cancer? How was it treated? _____
23. YES NO Have you ever had any major surgeries? What kind? _____
24. YES NO Have you ever been injured in an accident? When? _____
25. YES NO Have you ever had a severe blow to the head? When? _____
26. YES NO Are your hands and/or feet cold? How often? _____
27. YES NO Is your diet medically supervised? For what purpose? _____
28. YES NO Do you have difficulty swallowing? _____
29. YES NO Do you have a feeling of something stuck in your throat? _____
30. YES NO Do you ever have any facial pain or pressure? Where? _____
31. YES NO Do you ever have any pain or pressure behind your eyes? _____
32. YES NO Are you aware of stiff neck muscles? How often? _____
33. YES NO Have you been in traction for a neck injury? When? _____
34. YES NO Have you ever had or been advised to have neck surgery? _____
35. YES NO Do you have back pain? Where? _____
36. YES NO Do your ears feel itchy, stuffy or congested? _____
37. YES NO Do you have difficulty with pain in your ears when changing altitude? _____
38. YES NO Do your ears ring, buzz or hiss? How often? _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

39. YES NO Have you noticed any changes in your hearing? _____
40. YES NO Are you depressed? _____
41. YES NO Do you have emotional or anxiety/nervous problems? _____
42. YES NO Have you ever been treated for emotional or anxiety/nervous problems? _____
43. YES NO Have you gained or lost weight within the last year? How much? _____
44. YES NO Do you take more than one alcoholic drink per day? How many? _____
45. YES NO Do you use tobacco? How much? _____
46. YES NO Have you had any other serious illnesses, hospitalization or accidents? _____

Please explain: _____

Please list ALL medications and the dosage you are currently taking:

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Please list any allergies to any **medications**:

1. _____ 2. _____ 3. _____ 4. _____

Other allergies:

1. _____ 2. _____ 3. _____ 4. _____

DENTAL HISTORY:

47. YES NO When was your last dental visit? _____
48. YES NO Have you been told that you have periodontal (gum) disease? _____
49. YES NO Do you have any existing problems with your teeth? Describe _____
50. YES NO Is any dental treatment planned? Describe _____
51. YES NO Do you bite your nails? _____
52. YES NO Have you ever had oral surgery? _____
53. YES NO Have you lost any teeth? From what cause? _____
54. YES NO Have the teeth been replaced? When? _____
55. YES NO Have you ever had orthodontic treatment? When? _____
56. YES NO Have you ever had extensive dental treatment? When? _____
57. YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?
Where? _____
58. YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO

TMJ HISTORY

59. YES NO Do you ever have a burning or painful sensation in your mouth? _____
60. YES NO Do you get popping, clicking, or grinding noises when you open or close? _____
61. YES NO Do you ever awaken with an awareness of your teeth or jaws? _____
62. YES NO Are you aware of clenching during the daytime? How often? _____
63. YES NO Have you ever been told you grind your teeth during sleep? _____
64. YES NO Do you have trouble opening your mouth widely? _____
65. YES NO Does your jaw ever lock open or closed? How often? _____
66. YES NO Do you feel your bite is different, unstable or uncomfortable? _____
67. What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? _____
68. YES NO If you sought treatment for a TMJ problem, did it help? _____
69. YES NO Do you or have you had any pain in any of the following areas? (circle)
Jaw Ear Face Neck Teeth Head Other _____
70. YES NO Do your jaw problems affect your ability to chew? _____
71. YES NO Has your diet changed due to your jaw problems? Describe _____
72. YES NO Do your joint noises affect others while eating? _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

FAMILY HISTORY:

- 73. YES NO Do you have children. What are their ages? _____
- 74. YES NO Does your partner help you? _____
- 75. YES NO Do you have house guests? _____
- 76. YES NO Does your job satisfy you? _____

FOR WOMEN:

- 77. YES NO Are you pregnant? Expected delivery date? _____
- 78. YES NO Do you have a history of miscarriages? When? _____
- 79. YES NO Have you reached menopause? _____

SLEEP, SNORING AND APNEA HISTORY

- 80. YES NO Do you become easily fatigued? At what time of day? _____
- 81. YES NO Do you have problems with insomnia? _____
- 82. YES NO Do you sleep well? How long? _____
- 83. YES NO Do you dream? How often? _____
- 84. YES NO Do you have trouble falling asleep or staying asleep? Which _____
- 85. YES NO Do you snore or have you been told you do? _____
- 86. YES NO Do you wake up with a headache? _____
- 87. YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain? _____
- 88. YES NO Do you often fall asleep reading or watching television? _____
- 89. YES NO Have you fallen asleep during the day against your will? _____
- 90. YES NO Have you had to pull off the road while driving due to sleepiness? _____
- 91. YES NO Have you been more irritable and short tempered? _____
- 92. YES NO Have you felt that your memory and/or intellect is impaired? _____
- 93. YES NO Have you been told that you stop breathing while asleep? _____
- 94. About how many times per night do you wake up? _____
- 95. What time do you normally go to bed? _____ Get up in the morning? _____
- 96. Of the hours you are in bed, about how many hours are you asleep? _____
- 97. Would you rate the quality of your sleep as Good Fair Poor?
- 98. YES NO Do you have difficulty breathing through your nose? _____
- 99. Present body weight: _____ lbs. Height _____ ft. _____ inches.
- 100. YES NO Have you been diagnosed or treated for a sleep disorder? When _____
- 101. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder?
- 102. YES NO Have you ever had an evaluation at a sleep center?
 Sleep Center Name: _____
 Location: _____
 Sleep Study Date: _____
- 103. What professional advice or treatment have you received about your snoring or sleep apnea?

- 104. YES NO If you sought treatment for a sleep disorder, did it help? _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____	0 = Would never doze
Watching TV _____	1 = Slight chance of dozing
Sitting inactive in a public place (e.g. A theater or a meeting) _____	
As a passenger in a car for an hour without a break _____	2 = Moderate chance of dozing
Lying down to rest in the afternoon when circumstances permit _____	
Sitting and talking to someone _____	3 = High chance of dozing
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in traffic _____	

IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION AND TURN THE PAGE!

CPAP HISTORY

YES NO Do you wear a CPAP device **successfully** during sleeping?

How many hours per night do you wear your CPAP? _____

YES NO Have you tried other therapies for your sleeping disorder?

Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.) _____

If you are unable to wear a CPAP device, please check below reasons for your difficulty.

- Mask Leaks
- Mask Uncomfortable/Device Uncomfortable
- Unable to sleep comfortably
- Noise disturbs my sleep and/or bed partner's sleep
- Restricts movement during sleep
- Does not seem to be effective
- Straps/headgear cause discomfort
- Pressure on the upper lip causes tooth related problems
- Latex Allergy
- Claustrophobia
- Other _____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

<p style="text-align: center;">ORDER</p> <p>1. Please order your <i>chief complaints</i> by number: #1 being the 1st or <u>most</u> important, #2 the 2nd important, #3 the 3rd less important, #4, #5, #6, etc. (List all please)</p> <p style="text-align: right;">↓</p>	<p style="text-align: center;">FREQUENCY</p> <p>2. Rate your chief complaints for frequency as follows: 1= Seldom 2= Occasional 3= Frequent 4= Every Day</p> <p style="text-align: center;">↓</p>	<p style="text-align: center;">INTENSITY</p> <p>3. Rate the intensity of each complaint ordered on a scale from 0-10. 0= No Pain to 10= Most severe pain</p> <p style="text-align: right;">↓</p>
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<u>Chief Complaint</u>	<u>ORDER</u>	<u>Frequency</u> (1-4)	<u>Intensity</u> (0-10)	<i>For Office Use Only</i>
Jaw clicking/popping	_____	_____	_____	_____
Jaw joint noises	_____	_____	_____	_____
Jaw locking	_____	_____	_____	_____
Muscle twitching	_____	_____	_____	_____
Limited mouth opening	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Visual disturbances	_____	_____	_____	_____
Jaw pain	_____	_____	_____	_____
Facial pain	_____	_____	_____	_____
Ear pain	_____	_____	_____	_____
Back pain	_____	_____	_____	_____
Eye pain	_____	_____	_____	_____
Neck pain	_____	_____	_____	_____
Shoulder pain	_____	_____	_____	_____
Pain when chewing	_____	_____	_____	_____
Throat pain	_____	_____	_____	_____
Ear congestion	_____	_____	_____	_____
Sinus congestion	_____	_____	_____	_____
Ringling in the ears	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Frequent heavy snoring	_____	_____	_____	_____
Snoring which affecting sleep of others	_____	_____	_____	_____
Significant daytime drowsiness	_____	_____	_____	_____
Stop breathing when sleeping	_____	_____	_____	_____
Difficulty falling asleep	_____	_____	_____	_____
Gasping when waking up	_____	_____	_____	_____
Nighttime choking spells	_____	_____	_____	_____
Feeling unrefreshed upon waking	_____	_____	_____	_____
Morning hoarseness	_____	_____	_____	_____
Swelling in ankles or feet	_____	_____	_____	_____
Other	_____	_____	_____	_____

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

ATTORNEY INFORMATION

Are you involved in a lawsuit regarding your condition? Yes No

If you have an attorney representing you, please complete the following:

Attorney's Name _____

Paralegal _____

Phone Number _____

Address _____

City, State, Zip _____

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Please take a moment to read our office policies and feel free to ask any questions you may have.

CONSENT FOR TREATMENT

I hereby authorize Dalton Designer Smiles and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Dalton Designer Smiles and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated on the following page. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. **I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.**

FINANCIAL POLICY

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, check, MasterCard/Visa and Discover. For our patients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Patient Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 1.5% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. I understand that a credit history may be secured. Our returned check fee is \$50.

Our goal is to eliminate "billing surprises" so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

APPOINTMENTS

Should you need to cancel an appointment, we ask that you notify our office at least **24 hours in advance**. If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you will be charged a broken appointment fee of **\$75**.

I have read and understand Dalton Designer Smiles Consent for Treatment, Financial and Appointment policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.

Patient Signature: _____ Date: _____

Parent/
Responsible Party Signature: _____ Date: _____

Relationship: _____ Witness: _____

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. *Please initial* if you want us to send them a report from your visit.

<i>Initial</i> <u>FAMILY PHYSICIAN</u>	<i>Initial</i> <u>DENTIST</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
<i>Initial</i> <u>CHIROPRACTOR</u>	<i>Initial</i> <u>PHYSICAL THERAPIST</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
<i>Initial</i> <u>ENT</u>	<i>Initial</i> <u>CARDIOLOGIST</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
<i>Initial</i> <u>ALLERGIST</u>	<i>Initial</i> <u>NEUROLOGIST</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
<i>Initial</i> <u>PSYCHIATRIST</u>	<i>Initial</i> <u>PSYCHOLOGIST</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
<i>Initial</i> <u>SLEEP SPECIALIST</u>	<i>Initial</i> <u>OTHER</u>
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

- I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.
- I do not wish to have my records sent at this time.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____