

# TMJ | Orofacial Disorders Center

## Jason Pehling, DDS, MS

Dr. Pehling and his staff are pleased to welcome you to our clinic.

It is very important to arrive for your initial visit with Registration form, Health History form and Financial Policy and Agreement completed. We request that you not print on both sides of the forms.

### What you can expect on your initial visit to TMJ Orofacial Disorders Center

#### **Initial Visit**

Your initial visit begins with a comprehensive history and examination of your medical and dental condition. We ask that you reserve 2 hours for your initial visit. **Please bring with you any bite appliances or nightguards which you have been prescribed.**

#### **Diagnostic Testing**

In order to confirm clinical findings and to develop an appropriate treatment plan, diagnostic imaging studies are often necessary. **If your previous healthcare provider has taken a CT-scan or an MRI of your head, ear or TMJ, please have them forward them to our office.** If there is not enough time, please pick them up and bring them to your appointment. This will help us tremendously during your examination. If additional images are necessary, most can be taken at our office. Dr. Pehling will review your images with you. Unless your primary complaint is tooth pain, dental radiographs are not necessary.

#### **Treatment Plan**

Based upon the examination, Dr. Pehling will review with you which treatments will best help you achieve a healthy pain free state.

#### **Scheduling**

We try our best to stay on schedule to minimize your waiting. Due to the fact that Dr. Pehling provides personalized and comprehensive care, various circumstances may lengthen the time allocated for a procedure.

Emergency cases can also arise and cause delays. We appreciate your understanding and patience. When the Doctor or Assistant is with you, you will always be the most important patient in the office.

#### **Important**

A parent or guardian must accompany all patients under 18 at the initial evaluation visit.

#### **Payment**

Payment is due at the time of service. For your convenience we accept:

- Cash
- Check
- Visa or MasterCard
- Pre-approved financing

We deliver the finest care at a reasonable cost to our patients. We will give you a good faith estimate of expected charges before any treatment is rendered.

# TMJ | Orofacial Disorders Center

## Jason Pehling, DDS, MS

### Financing

Although our office isn't able to set up long term financing, we do work very closely with a healthcare finance company that offers wonderful programs to help patients receive medical/dental services they need today with an affordable payment plan.

Their programs range from **interest free** to long-term at a low interest rate. Please ask our financial coordinator about our finance partner so that she can give you more information.

### Insurance

Medical and Dental Insurance is a contract between you and your insurance company.

For your convenience, our office will submit your dental or medical claims electronically in order for you to be reimbursed directly by your insurance company as quickly as possible.

When there are both medical and dental benefits, the submittal for the medical claim will usually need to be held until we receive information back from your dental claim.

At TMJ Orofacial Disorders Center, we make every effort to provide you with the finest care and the most convenient financial options. To accomplish this we work hand-in-hand with you to maximize your insurance reimbursement for covered procedures. As we believe it is the doctor, together with the patient, that should determine patient care and not the insurance company, TMJ Orofacial Disorders Center is a non-participating, out-of-network provider of services.

Although we will do our best to help you understand your benefits, please remember that as the policyholder it is your responsibility to know as much about the plan as you can. During your evaluation our office will call insurance for your benefits. Please bear in mind that at times insurance representatives report incorrect information; therefore your actual benefits may differ from the information reported.

Please remember, you are ultimately fully responsible for all services rendered by this office regardless of your insurance coverage.

If you have any problems or questions, please ask our staff. They are well informed and up-to-date. They can be reached by phone at (206) 363-8240.

# TMJ | Orofacial Disorders Center

## Jason Pehling, DDS, MS

### Directions and Parking Instructions

#### Directions from the North

Take exit #173. Take the westbound branch to the stoplight and turn right. Get into the left lane. On the left are McDonald's, a Union 76 gas station, and then a three-story red brick building. We are in the three-story red brick building, second floor, suite 221. On the freeway side of the building is a sign on the building for *Everest College*.

#### Directions from the South

Take exit #173. Follow this exit to the light and turn left. Go to the next light and turn left. Stay in the left lane. Go under the freeway and through the next light. On your left are McDonald's, Union 76 gas station, and a three-story red brick building. We are in the three-story red brick building, second floor, suite 221. On the freeway side of the building is a sign on the building for *Everest College*.

#### Visitor Parking

Visitor parking and disabled parking is available on the second level of the building. To reach the entrance of upper level parking, drive to the corner of N. Northgate Way and turn south onto Meridian, turn Left into the driveway of upper level parking. **Or** enter upper level parking from the upper ramp on N. Northgate Way. Visitor level parking is limited to two hours and is monitored.

#### Parking under the Building

Underground parking is **Permit Parking Only**.

#### Parking at the Union 76 Gas Station

A second parking area location is the Union 76 gas station immediately east of our building. Drive into the station parking area. You will find spaces on the outside perimeter of the parking lot available to you.

**TMJ | Orofacial Disorders Center**  
Jason Pehling, DDS, MS

**Financial Policy and Payment Agreement**

Thank you for choosing TMJ Orofacial Disorders Center for your care. We are committed to providing you with excellent care. The following information is provided to acquaint you with our policies toward insurance and fees. This is an agreement which needs to be read and signed prior to any current and future treatment in this office. All patients will need to complete our information forms before being seen by a provider. If you have any questions regarding your account, please ask.

1. Each patient/guarantor is responsible for his or her own bill, regardless of insurance. As a courtesy, we will bill any insurance you may have though we are not contracted with insurance companies and are considered an out-of-network provider. We will need to copy all insurance cards that apply. Due to the nature of this practice, medical and/or dental insurance may or may not apply to your condition.
2. We encourage you to verify and know your insurance benefits.
3. If your insurance requires a referral or pre-authorization, it is necessary to have this in place prior to service being provided in order for any coverage to apply.
4. Verification of insurance coverage *DOES NOT* guarantee payment of your claim. Your insurance policy is a contract between you and the insurance company. It is your responsibility to understand completely the provisions of your insurance policy. If your insurance company fails to pay your claim, they must explain to you why it was denied. *Please do not penalize this office because of dissatisfaction with your insurance company's reimbursement policy.*
5. Checks returned for any reason are subject to a \$50.00 service fee.
6. Although our office isn't able to set up long term financing, we do work very closely with a healthcare finance company that offers programs to help patients receive medical/dental services today, yet pay it off over terms. Their programs range from interest free to long-term at a low interest rate. Please call our office for more information.
7. Patients are expected to keep appointments. If a patient cannot keep an appointment, they are expected to notify us of the cancellation at least 24 hours in advance, whenever possible, so that other patients can be seen. The office is open Monday – Thursday, 9:00 to 5:00, and cancellations require the patient to speak with the office. Patients who fail to keep an appointment are subject to a no-show fee of \$100.00, which must be paid prior to being seen for the next appointment.
8. You are fully responsible for payment of your services regardless of insurance. If you have any problems or questions, please ask our staff. They can be reached by phone at (206) 363-8240

**Authorization to Release Information**

I hereby authorize this office to release all information concerning my medical treatment to my insurance/managed care company and/or my healthcare providers (if any).

By signing this agreement, the undersigned agrees to abide by the policies of this office and understands their responsibilities as explained above.

Signed: \_\_\_\_\_

Staff: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TMJ | Orofacial Disorders Center**

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt City State Zip Code

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Nearest Relative not living with you Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

Patient: Employed  Student

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

In case of Emergency Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT**  SELF  SPOUSE  MOTHER  FATHER  OTHER

Name \_\_\_\_\_ SS# \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt City State Zip Code

Employer \_\_\_\_\_ Home /Mobile Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_

**SPOUSE OR GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)**

Name \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip Code

Employer \_\_\_\_\_ Home /Mobile Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

**WHO MAY WE THANK FOR YOUR REFERRAL?**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Address \_\_\_\_\_

**INSURANCE INFORMATION** We bill for you both Medical and Dental for TMJ disorders. Please fill out all insurance information.

Are you a MEDICARE recipient: YES  NO  Is your Medicare through an HMO: YES  NO  Supplemental Insurance: YES  NO

**DENTAL INSURANCE** Additional boxes on back for Motor Vehicle or Work Injuries

Dental Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

SS# / ID # \_\_\_\_\_ Group #: \_\_\_\_\_ Plan \_\_\_\_\_

Employer/Group Name \_\_\_\_\_ Do you need a referral? YES  NO

**MEDICAL INSURANCE** Additional boxes on back for Motor Vehicle or Work Injuries

Medical Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_

SS# / ID # \_\_\_\_\_ Group #: \_\_\_\_\_ Plan: \_\_\_\_\_

Employer/Group Name \_\_\_\_\_ Do you need a referral? YES  NO

TMJ | Orofacial Disorders Center

WORK INJURY  Labor & Industries  Self-Insured  Company

Claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Date of Loss \_\_\_\_\_ Claim Manager Name \_\_\_\_\_  
Claim Manager Phone # \_\_\_\_\_ Claim Manager Fax # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Attending Physician Name \_\_\_\_\_ Attending Physician phone # \_\_\_\_\_  
Do you have permission from your claims manager to be seen here? ( ) Yes ( ) No  
Do you have an Attorney? ( ) Yes ( ) No  
Attorney Name \_\_\_\_\_ Attorney Phone # \_\_\_\_\_ Attorney Fax# \_\_\_\_\_

**AUTO OR OTHER ACCIDENT**

Date of Loss \_\_\_\_\_ County of Accident/Injury \_\_\_\_\_  
Your PIP Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_  
Your PIP Claims Address \_\_\_\_\_  
Claims Adjuster Name \_\_\_\_\_  
Adjuster Phone # \_\_\_\_\_ ext \_\_\_\_\_ Adjuster FAX # \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ DOB \_\_\_\_\_  
Insured SS# \_\_\_\_\_ Insured Policy # \_\_\_\_\_ PIP Limits \_\_\_\_\_  
Is Claim open Yes \_\_\_\_\_ No \_\_\_\_\_

**ATTORNEY**

If you have an attorney as a result of your injury, what is the Attorney Name \_\_\_\_\_  
Attorney Address \_\_\_\_\_ Phone # \_\_\_\_\_ FAX # \_\_\_\_\_

**THIRD PARTY INFORMATION** – This information is necessary

Third Party Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_  
Third Party Insurance Address \_\_\_\_\_  
Third Party Insurance Adjuster \_\_\_\_\_  
Third Party Insurance Phone# \_\_\_\_\_ ext \_\_\_\_\_ FAX # \_\_\_\_\_  
Third Party Insured Name \_\_\_\_\_  
Third Party Insured Address \_\_\_\_\_

The above information is true and correct to the best of my knowledge. I understand that my full payment is due at the time services are rendered. I authorize my insurance benefits to be paid directly to the TMJ Orofacial Disorders Center when private payment is deferred through financial arrangements. To the extent permitted by law, I authorize the release of any information related to this claim. I consent to evaluation.

\_\_\_\_\_  
Signature of Patient or Responsible Party Date

\_\_\_\_\_  
Print Name

## HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. The information you provide is confidential and will allow us to provide you the best care possible.

**Date:** \_\_\_\_\_

<b>Name:</b> _____						
First	M	Last	Age			
<b>Referring Doctor:</b> _____						
First	M	Last	Credentials			
<b>Address:</b> _____						
Street	Ste.#	City	State	Zip	Phone	
<b>Primary Care Physician:</b> _____						
First	M	Last	Credentials			
<b>Address:</b> _____						
Street	Suite #	City	State	Zip	Phone	
<b>Primary Dentist:</b> _____						
First	M	Last	Credentials			
<b>Address:</b> _____						
Street	Suite #	City	State	Zip	Phone	
<b>Other Practitioner:</b> _____						
First	M	Last	Credentials			
<b>Address:</b> _____						
Street	Suite #	City	State	Zip	Phone	
<b>Other Practitioner:</b> _____						
First	M	Last	Credentials			
<b>Address:</b> _____						
Street	Suite #	City	State	Zip	Phone	

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

Please number your complaints: <b>#1 being the most important, #2 the next important, etc.</b>			
Then, rate your complaints for frequency and intensity: <b>Frequency: (1-Seldom, 2-Occasional, 3-Frequent, 4-Every Day)</b> <b>Intensity: (0 is No Pain and 10 is Most Severe Pain)</b>			
	Number	Frequency	Intensity
Back Pain			
Dizziness			
Ear Congestion			
Ear Pain			
Eye Pain			
Facial Pain			
Fatigue			
Headaches			
Jaw Clicking			
Jaw Joint Noises			
Jaw Locking			
Jaw Pain			
Limited Mouth Opening			
Muscle Twitching			
Neck Pain			
Pain when Chewing			
ringing in Ears			
Shoulder Pain			
Sinus Congestion			
Throat Pain			
Visual Disturbances			
Other:			

Please tell us on a 0-10 scale (0 being no effect and 10 being unable to perform) to what degree your symptoms have interfered with the activities of daily living (i.e. sleeping, working, leisure activities, eating, etc.) \_\_\_\_\_

# MEDICAL HISTORY FORM

Patient Name: (Last, First, M)	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Please list all major HOSPITALIZATIONS OR SURGERIES for any surgical operation or illness in the past.

Date	Reason for Procedure	Name and Address of Hospital

Please list any MAJOR ILLNESSES OR SPECIAL MEDICAL OR PSYCHOLOGICAL PROBLEMS that you have now or have had in the past.


What **MEDICATIONS** are you **CURRENTLY** taking for any health problems?

Medication Name	Dosage per Day (mg, cc, etc)	Times per Day	Reason	Length of Time Taken

What **MEDICATIONS** have you taken for the problem **IN THE PAST** but not now?

Medication Name	Dosage per Day (mg, cc, etc)	Times per Day	Reason	Length of Time Taken

Please list any **Allergies** to medications:

Medication Name	Dosage per Day (mg, cc, etc)	Times per Day	Reason	Length of Time Taken

<b>HEALTH PROBLEMS: Please check all health problems that you currently have or had in the past</b>			
	<b>Yes</b>		<b>Yes</b>
<b>Cardiovascular</b>		<b>Infectious Disease</b>	
Rheumatic fever/heart disease	<input type="checkbox"/>	Sexually transmitted disease(syphilis, gonorrhea, genital herpes)	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	Hepatitis: Type _____	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>
Infective endocarditis	<input type="checkbox"/>	Other current infectious disease	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>		
High cholesterol	<input type="checkbox"/>	<b>Genitor-Urinary</b>	
Angina	<input type="checkbox"/>	Bladder problems/infections	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
Congenital heart defect or lesion	<input type="checkbox"/>	Urinary retention or difficulty urinating	<input type="checkbox"/>
Heart surgery/angioplasty	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>
Pacemaker/defibrillator	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<b>Hematologic/Lymphatics</b>	
Vascular disease or surgery	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Racing heart (palpitations)	<input type="checkbox"/>	Hemophilia/other bleeding disorders	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>
Swollen feet/ankles	<input type="checkbox"/>	Sickle Cell Anemia Disease	<input type="checkbox"/>
Other heart problems	<input type="checkbox"/>	Tumor or Cancer	<input type="checkbox"/>
		Chemotherapy	<input type="checkbox"/>
<b>Respiratory</b>		Radiation therapy	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Bleed for a long time	<input type="checkbox"/>
Bronchitis/Pneumonia	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>
<b>Allergic/Immunologic</b>		<b>Eyes</b>	
Hay Fever	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Anaphylactic shock reaction	<input type="checkbox"/>	Full or partial blindness	<input type="checkbox"/>
Reaction to foods:	<input type="checkbox"/>	Double vision	<input type="checkbox"/>
Type of food: _____	<input type="checkbox"/>	Blind spots	<input type="checkbox"/>
Reaction to local anesthetic (novacaine)	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>
Reaction to penicillin, other antibiotics	<input type="checkbox"/>		
Reaction to sulfa drugs	<input type="checkbox"/>	<b>Women</b>	
Reaction to sedatives, or sleeping pills	<input type="checkbox"/>	Are you taking contraceptives	<input type="checkbox"/>
Reaction to barbiturates	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>
Reaction to aspirin or other pain medication	<input type="checkbox"/>	Are you nursing presently	<input type="checkbox"/>
Reaction to iodine	<input type="checkbox"/>	Had a hysterectomy or ovariectomy	<input type="checkbox"/>
Reactions to other medications	<input type="checkbox"/>	Are you on hormone replacement therapy	<input type="checkbox"/>
List: _____		Dysmenorrhea (painful menstrual periods)	<input type="checkbox"/>
		Premenstrual syndrome (PMS)Menopause	<input type="checkbox"/>
<b>Gastrointestinal</b>		Breast Cancer	<input type="checkbox"/>
Stomach/intestinal ulcers	<input type="checkbox"/>		
Gastric Reflux	<input type="checkbox"/>	<b>Men</b>	
Colitis	<input type="checkbox"/>	Testicular tumors or disorders	<input type="checkbox"/>
Liver disease/jaundice	<input type="checkbox"/>	Prostatitis	<input type="checkbox"/>
Gall bladder stones	<input type="checkbox"/>	Prostrate cancer	<input type="checkbox"/>
Persistent diarrhea	<input type="checkbox"/>		
Persistent constipation	<input type="checkbox"/>	<b>Ear and Nose, and Throat</b>	
Bloody or black stools	<input type="checkbox"/>	Sinusitis or sinus headache	<input type="checkbox"/>
		Nasal rhinitis	<input type="checkbox"/>
<b>Skin/Integumentary</b>		Inner ear infections	<input type="checkbox"/>
Allergy to latex (rubber)	<input type="checkbox"/>	Tinnitus/ Ringing in ear	<input type="checkbox"/>
Psoriasis (chronic skin rash)	<input type="checkbox"/>	Frequent nasal congestion	<input type="checkbox"/>
		Vertigo (head spinning)	<input type="checkbox"/>
<b>Endocrine</b>		Hearing difficulty/loss	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Plugged ears	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>		
Pancreatic disease	<input type="checkbox"/>		

**HEALTH PROBLEMS: Please check all health problems that you currently have or had in the past**

	<b>Yes</b>		<b>Yes</b>
<b>Neurologic</b>		<b>Mental Health</b>	
Multiple sclerosis (MS)	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Epilepsy, seizures or convulsions	<input type="checkbox"/>	Anxiety disorder	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	Mental health treatment	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	Physical or sexual abuse	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	Stressed out/overwhelmed	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	Low energy level	<input type="checkbox"/>
Wake up from headache	<input type="checkbox"/>	Crying spells	<input type="checkbox"/>
Fainting, dizzy spells or black-outs	<input type="checkbox"/>	Sleep problems/insomnia	<input type="checkbox"/>
Speech difficulty/slurring	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>
Facial weakness/drooping	<input type="checkbox"/>	Trouble relaxing	<input type="checkbox"/>
Facial twitching	<input type="checkbox"/>	Felt like taking your own life in past 6 months	<input type="checkbox"/>
Tingling or numbness in face	<input type="checkbox"/>	Do you feel your heart racing	<input type="checkbox"/>
Tingling or numbness in arms/fingers	<input type="checkbox"/>	Do you often feel depressed	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	Do you frequently feel angry	<input type="checkbox"/>
Balance problem	<input type="checkbox"/>	Do you feel your mood or personality changed recently	<input type="checkbox"/>
Weakness in parts of body	<input type="checkbox"/>	Other (please list)	
<b>Musculoskeletal/Rheumatic</b>		<b>Chemical Use</b>	
Fibromyalgia	<input type="checkbox"/>	Coffee daily	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	Beer or wine daily	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	Tea daily	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Cocktails or other alcoholic beverages daily	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	Soft drinks (pop) daily	<input type="checkbox"/>
Artificial Joint (knee/hip/other)	<input type="checkbox"/>	Chewing tobacco	<input type="checkbox"/>
Sjogren's syndrome	<input type="checkbox"/>	Cocaine or other stimulants	<input type="checkbox"/>
Swollen or painful joints	<input type="checkbox"/>	Drug/alcohol dependency (current/recovering)	<input type="checkbox"/>
Hand/wrist pain/carpel tunnel	<input type="checkbox"/>	Take alcohol or recreational drugs to help with pain	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	Immediate family members chemically dependent	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>		
Shoulder and upper back pain	<input type="checkbox"/>		

**DENTAL and OROFACIAL HISTORY**

**Have you had any of the following dental treatments or problems?**

	<b>Yes</b>		<b>Yes</b>
Orthodontic braces	<input type="checkbox"/>	<b>TMJ</b>	
Orthognatic or bite surgery	<input type="checkbox"/>	Jaw joint clicking or popping noise	<input type="checkbox"/>
Wisdom teeth extracted	<input type="checkbox"/>	Jaw joint grating or crepitus noise	<input type="checkbox"/>
Other teeth extracted	<input type="checkbox"/>	Jaw locking or getting stuck open	<input type="checkbox"/>
Bite adjusted	<input type="checkbox"/>	Jaw locking closed/cannot open all the way	<input type="checkbox"/>
Splint or bite guard	<input type="checkbox"/>		
Upper full denture	<input type="checkbox"/>	<b>Mouth Lesions or Disease</b>	
Lower full denture	<input type="checkbox"/>	Burning or painful tongue	<input type="checkbox"/>
Mouth biopsy	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>
Missing teeth need replacement	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>
Need new crown(s) or filling(s)	<input type="checkbox"/>	Tongue sores	<input type="checkbox"/>
Tooth wear or fracture	<input type="checkbox"/>		
Persistent tooth pain	<input type="checkbox"/>	Fever blisters/Cold sores on lips	<input type="checkbox"/>
Tooth or teeth sensitive to hot/cold	<input type="checkbox"/>	Lumps or bumps in mouth	<input type="checkbox"/>
Painful tooth when biting on it	<input type="checkbox"/>	Swelling in mouth	<input type="checkbox"/>
Difficulty chewing due to bite	<input type="checkbox"/>	Mouth ulcers or canker sores	<input type="checkbox"/>
Unstable bite	<input type="checkbox"/>	Colored or discolored areas in mouth	<input type="checkbox"/>
Bite that is changing	<input type="checkbox"/>		
Cross bite	<input type="checkbox"/>		
Open bite	<input type="checkbox"/>		

<b>Oral Habits: Have you or others noticed yourself doing any of the following oral habits regularly (more than once a week)?</b>			
	<b>Yes</b>		<b>Yes</b>
Chewing on one side	<input type="checkbox"/>	<b>Periodontal (Gums)</b>	
Leaning on the jaw	<input type="checkbox"/>	Periodontal disease	<input type="checkbox"/>
Grinding the teeth at night	<input type="checkbox"/>	Gingivitis or bleeding gums	<input type="checkbox"/>
Grinding your teeth when awake	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>
Waking up with sore jaws	<input type="checkbox"/>	Deep pockets in gums	<input type="checkbox"/>
Clenching your teeth when awake	<input type="checkbox"/>	Sore gums	<input type="checkbox"/>
Clenching your teeth at night	<input type="checkbox"/>	Impacted or unerupted teeth	<input type="checkbox"/>
Holding your jaw forward	<input type="checkbox"/>		
Chewing gum	<input type="checkbox"/>	<b>Oral obstructive Sleep/Breathing Problems</b>	
Playing a musical instrument with the mouth	<input type="checkbox"/>	Snore loudly or have sleep apnea	<input type="checkbox"/>
Sleeping on stomach	<input type="checkbox"/>	Stop breathing while sleeping	<input type="checkbox"/>
Touching or holding your teeth together	<input type="checkbox"/>	Choke or struggle for breath while sleeping	<input type="checkbox"/>
Holding or pressing the tongue against your teeth	<input type="checkbox"/>	Wake up feeling tired	<input type="checkbox"/>
Holding your jaw in a rigid or tense position	<input type="checkbox"/>	How many hours of sleep	_____
Biting objects (pens, tooth picks, etc.)	<input type="checkbox"/>	Do you have difficulty staying asleep	<input type="checkbox"/>
Biting your cheeks	<input type="checkbox"/>	Do you frequently feel fatigued	<input type="checkbox"/>
Biting your nails or cuticles	<input type="checkbox"/>		
Biting your lips	<input type="checkbox"/>		
Biting your tongue	<input type="checkbox"/>		
Bracing the phone with shoulder or jaw	<input type="checkbox"/>		
<b><u>Mouth or Facial Injury</u></b>			
Have you had trauma or injury to your jaw, head, or neck?	<input type="checkbox"/>		
Describe:			
Have you or will you consult an attorney about this condition?	<input type="checkbox"/>		
Describe:			
<b><u>Comments:</u></b>			

**How did your symptoms begin?**

**What is your occupation?**

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**Do you have any children living with you?    Yes     No**

**If so, how many children?**

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**Are you:    Married    Single    Divorced    Widowed**

I have read and understand the above questions. I acknowledge that my questions, if any about the inquiries set forth above, have been answered to my satisfaction. I will not hold Dr. Jason Pehling responsible for any errors or omissions that I may have made in the completion of this form. I give permission for a letter detailing the findings from my history and examination, including my medical history, to be sent to my healthcare providers and any healthcare providers that I am referred to for care.

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Signature

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Date

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Print Name

# TMJ | Orofacial Disorders Center

## Jason Pehling, DDS, MS

### **STATEMENT OF PRIVACY PRACTICES**

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

#### **Protecting Your Personal Healthcare Information**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act of the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

#### **Collecting Protected Health Information**

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

#### **Disclosure of your Personal Health Information**

As stated, above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voice mail messages, answering machine, and postcards.

#### **Patient Rights**

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than that stated above. All such requests must be in writing. We may charge for your copies in the amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

**TMJ | Orofacial Disorders Center**  
**Jason Pehling, DDS, MS**

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of TMJ Orofacial Disorders. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Jason Pehling, DDS, MS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

**ADDITIONAL DISCLOSURE AUTHORITY**

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

<b>Any Member Of My Immediate Family</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Spouse Only</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
<b>Other (Please Specify):</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>

\_\_\_\_\_  
Name of Patient or Personal Representative

**x** \_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

**OFFICE USE ONLY BELOW THIS LINE**

**Record of Acknowledgement not obtained**

Provided Prior To Treatment?       **YES**     **NO**

DATE PROVIDED: \_\_\_\_\_

REASON FOR DENIAL:

- \_\_\_\_\_ **NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES**
- \_\_\_\_\_ **WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING**
- \_\_\_\_\_ **UNABLE TO SIGN**
- \_\_\_\_\_ **REASON NOT GIVEN**
- \_\_\_\_\_ **OTHER (EXPLAIN):**