Hi,

Thank you for selecting FMY Orthodontics to care for your treatment needs. We are looking forward to seeing you in soon.

Your visit will involve a comprehensive, no-charge, TMJ examination. If treatment is recommended, we will have plenty of time to discuss the treatment plan, the estimated treatment time and the fees associated with this service.

If you have insurance that covers either TMJ or orthodontic treatment, please make sure we have that information before the day of your examination so we can give you an estimated benefit during the appointment.

We have included some important forms with this letter. Please complete them ahead of time and bring them with you to your next appointment.

We are looking forward to a relaxed and pleasant visit with you. Please call or visit our website at www.fmyortho.com for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Doctors & Staff of
FMY Orthodontics

FMY Orthodontics
Drs. Merwin, Miller and Thomas
Jackson ♦ Martin ♦ Dyersburg ♦ Henderson♦ Bolivar ♦ Brownsville
(731)668-8922 1-800-548-5303 www.fmyortho.com

MEDICAL HISTORY

Patient's Name ____ Date ______________________________

Dentist's Name _____________________________________ Date of Last Dental Exam ________________________

Physician's Name ___________________________________ Date of Last Physical Exam ______________________

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotics
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other _______________

Medications:

Please list medications, nutrient supplements, herbal medications & non prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

Y __ N __ Adenoids or tonsils removed
Y __ N __ Arteriosclerosis (hardening of the arteries)
Y __ N __ Asthma, hay fever, sinus trouble or hives
Y __ N __ Autoimmune disorders or immune system problems
Y __ N __ Bleeding or bruising easily
Y __ N __ High or low blood pressure – please circle
Y __ N __ Cancer, tumor, chemotherapy or radiation treatment
Y __ N __ Chronic fatigue
Y __ N __ Current pregnancy
Y __ N __ Depression or other mental health disturbance
Y __ N __ Diabetes
Y __ N __ Dizziness
Y __ N __ Epilepsy or other seizure disorder
Y __ N __ Fibromyalgia
Y __ N __ General anesthesia
Y __ N __ Hearing impairment
Y __ N __ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y __ N __ Frequent coughs, colds or sore throats
Y __ N __ Hemophilia
Y __ N __ Hepatitis, AIDS or HIV positive
Y __ N __ Injury to face, neck, mouth or teeth – please circle
Y __ N __ Insomnia
Y __ N __ Jaw joint surgery
Y __ N __ Kidney or liver problems
Y __ N __ Meniere's disease
Y __ N __ Multiple sclerosis
Y __ N __ Muscular dystrophy
Y __ N __ Nighttime breathing problems (snoring or sleep apnea)
Y __ N __ Nervousness
Y __ N __ Neuralgia
Y __ N __ Osteoarthritis (stiff or swollen joints)
Y __ N __ Osteoporosis
Y __ N __ Parkinson's disease
Y __ N __ Prior orthodontic treatment
Y __ N __ Psychiatric care
Y __ N __ Rheumatic fever
Y __ N __ Rheumatoid arthritis
Y __ N __ Scarlet fever
Y __ N __ Skin disorder
Y __ N __ Speech difficulties
Y __ N __ Stroke or heart attack
Y __ N __ Tuberculosis
Y __ N __ Wisdom teeth extraction
Y __ N __ Birth defects or hereditary problems
Y __ N __ Endocrine or thyroid problems
Y __ N __ Stomach ulcer or hyperacidity
Y __ N __ Polio, mononucleosis or pneumonia
Y __ N __ Vision problems
Y __ N __ Loss of weight recently, poor appetite
Y __ N __ Eating disorder (anorexia or bulimia)
Y __ N __ Chest pain, shortness of breath or swelling ankles
Y __ N __ Frequent or severe headaches
Y __ N __ Other condition ___________________________

Emergency Contact ___________________________ Relationship ________________ Phone # __________________

Patient/Parent Signature ____ Today's Date _____________________

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TMJ QUESTIONNAIRE

Patient's Name ______________________ Date ______________

Chief Complaint: What are the main symptoms for which you are seeking treatment (please be specific)?

Treatment History: List any health professionals you have seen and any treatment you have received for this condition:

Symptoms:

Head Pain – Circle Affected Side

(L=Left R=Right B=Both Sides)		Severity			Frequency			Duration				
		Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
L R B	Front of Head (Frontal)	__	__	__	__	__	__	__	__	__	__	__
L R B	Entire Head (Generalized)	__	__	__	__	__	__	__	__	__	__	__
L R B	Top of Head (Parietal)	__	__	__	__	__	__	__	__	__	__	__
L R B	Back of head (Occipital)	__	__	__	__	__	__	__	__	__	__	__
L R B	Temple Area (Temporal)	__	__	__	__	__	__	__	__	__	__	__

Jaw Pain – Circle Affected Side

L R B Jaw Pain on Opening
L R B Jaw Pain while Chewing
L R B Jaw Pain at Rest

Jaw Symptoms – Check Yes or No

Y __N__ Jaw Clicks
Y __N__ Jaw Locks Closed
Y __N__ Jaw Locks Open
Y __N__ Jaw Pops
Y __N__ Teeth Clenching
Y __N__ Teeth Grinding

Eye Related Conditions – Check Yes or No

Y __N__ Blurred Vision
Y __N__ Double Vision
Y __N__ Eye Pain
Y __N__ Pain/Pressure Behind Eyes
Y __N__ Light Sensitivity

Ear Related Conditions – Check Yes or No

Y __N__ Buzzing in Ears
Y __N__ Ear Congestion
Y __N__ Ear Pain
Y __N__ Hearing Loss
Y __N__ Pain Behind the Ear
Y __N__ Pain in Front of the Ear
Y __N__ Recurrent Ear Infections
Y __N__ Tinnitus (ringing in the ear)

Throat, Neck & Back Conditions – Check Yes or No

Y __N__ Back Pain - Lower
Y __N__ Back Pain - Middle
Y __N__ Back Pain - Upper
Y __N__ Chronic Sore Throat
Y __N__ Lump in Throat
Y __N__ Difficulty Swallowing
Y __N__ Limited Movement of Neck
Y __N__ Neck Pain
Y __N__ Numbness in Hands/Fingers
Y __N__ Sciatica
Y __N__ Scoliosis
Y __N__ Shoulder Pain
Y __N__ Shoulder Stiffness
Y __N__ Swelling in the Neck
Y __N__ Swollen Glands
Y __N__ Thyroid Enlargement
Y __N__ Tightness in Throat
Y __N__ Tingling in Hands/Fingers
Y __N__ Wryneck

Mouth & Nose Conditions – Check Yes or No

Y __N__ Broken Teeth
Y __N__ Burning Tongue
Y __N__ Chronic Sinusitis
Y __N__ Dry Mouth
Y __N__ Frequent Cheek Biting
Y __N__ Frequent Snoring

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TMJ QUESTIONNAIRE

Patient's Name ______________________________ Date ____________________

History of Symptoms:

When did your condition first occur?

What do you believe caused your condition?

If caused by a motor vehicle accident, work or school-related incident or fight, what was the date of injury?

Is there anything that makes your condition worse?

Is there anything that makes your condition better?

What other information is important to your condition?

Family History:

Have any family members (blood-related) had:

__Y __N Severe Headaches
__Y __N Heart Disease
__Y __N High Blood Pressure
__Y __N Diabetes

Social History:

Occupation: ____________________

__Y __N Do you have children? If yes, how many? ____ What are their ages? ____________
__Y __N Are you currently under unusual stress?
__Y __N Have you had a recent change in lifestyle?
__Y __N Do you exercise regularly?
__Y __N Do you chew tobacco?
__Y __N Do drink coffee or other caffeinated drinks? If yes, how many per day? ____
__Y __N Do you smoke? If yes, how many cigarettes per day? ____
__Y __N Do you drink alcohol? If yes, is it occasional, social, or daily? ____________

Patient/Parent Signature ______________________________ Today's Date ________________

TMJ INFORMED CONSENT

Patient's Name ____ Date ____________________________

A proper diagnosis regarding head and neck pain is very important because serious medical problems such as vascular disorders, brain tumors, cervical disc disorders, etc. produce similar symptoms of TMJ disorders. It is important to inform our office of any change in your health history.

Length of treatment may vary according to the complexity; of your condition. Treatment times may therefore vary from estimates. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits, bite relationship, etc. do affect the outcome and total resolution is not always possible.

The type of treatment methods we will use is based on our experience and knowledge to be the most proven, appropriate, cost effective, and conservative. However, you should be aware there is much debate in the medical-dental community regarding what is the best way to treat various TMJ disorders.

As with any medical or dental treatment, unusual occurrences can and do happen. These possibilities could include minor tooth movement, loosened teeth or dental restoration, sore mouth, periodontal problems, muscle spasm, ear pain, neck pain, etc. Any of the mentioned complications are rare, but theoretically may occur.

Good communication is essential to successful treatment. Please feel free to discuss any questions you many have regarding any problems of treatment. Referrals to other professionals such as physical therapists, nutritionist, chiropractors, medical doctors, neurologists, or ear, nose and throat specialists may be indicated and necessary for successful treatment.

I consent to the taking of photographs and x-rays before, during and after TMJ treatment as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for the use of these photographs, x-rays and records t be used for the purpose of research, education of publication in professional journals.

With any medial or dental treatment, the success depends to a large extent on the degree of cooperation of the patient in following the prescribed treatment plan. Failure to comply with instructions could delay the treatment time and seriously affect the success of the treatment.

I understand that the wearing of the splint (plastic mouth piece) on my lower teeth is for diagnostic purposes only and is not a permanent solution to my jaw joint (TMJ), head, neck or facial pain problems. If the splint therapy is successful then our doctors will discuss other treatment options.
Patients must be aware that a final finishing stage is usually required following the initial splint therapy.

Patient/Parent Signature ______________________________________ Today's Date ____________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Office Use Only

Patient's Legal Name ____

Section B: To the Patient – Please Read these 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 is available upon request with 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 make available upon request 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 revision of our Notice, at any time by contacting:

Contact Person:	Cynthia Pham
Telephone:	731-668-8922 ext 111
Email:	cpham@fmyortho.com
Address:	190 Murray Guard Dr Jackson, TN 38305

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or 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.

Section C: 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 health care operations.

Patient/Parent Signature ____ Today's Date __________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

FINANCIAL RESPONSIBILITY FOR TMJ TREATMENT AND AUTHORIZATION FOR SIGNATURE ON FILE

I understand and agree that after the complimentary examination, I am responsible for any charges that I and/or my dependent incur and authorize during treatment at the time services are rendered, regardless of insurance coverage.

I understand that FMY Orthodontics will attempt to verify whether or not TMJ treatment is covered by my insurance company, but makes no guarantees of payment by insurance company.

I understand that FMY Orthodontics will file claims for services rendered and do their best to solve claims problems, but cannot accept assignment of these benefits. All insurance benefits will be paid directly to the subscriber.

I understand that FMY Orthodontics is an out of network provider for all medical insurance policies.

To the extent permitted under applicable law, I hereby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I agree to furnish the insurance company and FMY Orthodontics with any additional information or paperwork requested to expedite payment of my claim.

I agree that a photocopy of this document and authorization may act as an original.

Insurance Subscriber's Signature ____ Today's Date ____________________