ADVANCED
DENTISTRY OF AMARILLO
Aesthetic Smile Design • TMJ • Sleep & Airway
Trey H. Miller, DDS, FAGD, LVIF

6834 Plum Creek Drive • Amarillo TX 79124 (806) 358-8021

New Patient Form

Patients Name: Last: _____ First: _____ MI: ___ Preferred Name: _____

Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Mobile: _____ Work: _____ Ext:_____

Birth Date: _____ Email Address: _____ Best Number to Call:_____

Gender:

☐ Male ☐ Female

Preferred Appointment Times:

☐ Anytime ☐ Morning ☐ Afternoon ☐ Mon ☐ Tues ☐ Wed ☐ Thurs

May we ask how you heard about our Office?

☐ Another Dental Office ☐ Physician ☐ Internet ☐ Accent West Magazine ☐ TV

☐ Google ☐ Bing ☐ Yelp ☐ Facebook ☐ Friend

☐ Other: _____

If a specific person referred you to our office please list their name here so we may thank them:

_____

_____

_____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information (If other than Patient)

The Following is for: ☐ The patient's spouse ☐ Patients parent/guardian
☐ Other person responsible for payment

Name: Last: _____ First: _____ MI:____ Preferred Name: _____

Title: Mr/Ms/Mrs/Dr _____ Gender: ☐ Male ☐ Female

Birth Date: _____ Email Address: _____

Phone: Home _____ Mobile _____ Work _____ Ext _____

Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Primary Insurance Information

Primary Dental Insurance

Name of Insured: Last _____ First _____ MI____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Employer Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you have secondary dental insurance?

☐ Yes ☐ No

Primary Medical Insurance:

Name of Insured: Last _____ First _____ MI____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Insured's Employers Name: _____

Employer Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you have secondary dental insurance?

☐ Yes ☐ No

Consents and Releases

Please INITIAL and SIGN below:

_____ I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

_____ I hereby authorize Dr. Miller and/or their team members to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, and demonstrations by Dr. Miller and/or their team members.

_____ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Miller and/or their team members for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand that I will receive no further financial compensation for the use, at any time in the future, of my testimonials, photos, slides, or videos by Dr. Miller or his team members.

_____ I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

_____ I acknowledge that Dr. Miller is out-of-network provider for all dental insurance companies so that patients are empowered to make their own decisions about their dental treatment, without the interference of a third party insurance company. As a courtesy to our patients, dental benefit claim forms will be completed by our office and given to each patient in a pre-filled envelope to submit to their dental insurance carrier. This way, any dental benefits received will then be sent directly to the patient.

_____ Since each appointment I make is time reserved specifically for me with the doctor or hygienist, I will provide 48 hours advance notice for any appointment cancellations. Advanced Dentistry of Amarillo reserves the right to impose a cancellation fee for appointments canceled with short notice (less than 48 hours) or no-show appointments. Cancellation/no-show fees are: $50 for appointments booked for less than 1.5 hours and $150 for appointments booked for 1.5 hours or longer. Such cancellation fees are non-refundable and must be collected before reserving another appointment time slot.

_____ I have read and understood this entire agreement before signing below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of this agreement simultaneously upon my endorsing it.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

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

___Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

Response Date

___/___/_____

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Medical & Dental History

Patient Name: _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in good health? ☐ Yes ☐ No

Within the past year, have there been any changes in your general health? ☐ Yes ☐ No

What is the date (or approximate date) of your last medical exam?
_____

Your Primary Care Physician's name and phone number
_____
_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Have you ever had Botox injections? If so, when was the last one?

WOMEN ONLY: Are you pregnant? Yes___ No___
If Yes, When is the due date? _____
Taking birth control pills? Yes___ No___
Are you taking hormones? Yes___ No___

Health History
Please indicate if you have experienced the following:

Check the box to indicate a yes response.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Pressure High
- ☐ Blood Pressure Low
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatment
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ____
- ☐ Herpes
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Tumor or Growth
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained
- ☐ Other _____

Height:_____ Weight:_____

Social History

Please mark any of the following to indicate YES in response to the question.

- ☐ Do you use recreational drugs?
- ☐ Do you use tobacco products?
- ☐ Do you drink alcohol?
- ☐ Do you consume caffeine?
- ☐ Do you take pain relievers?
- ☐ Do you use antidepressants or sleeping pills?
- ☐ Are you on any blood thinners, including aspirin?

If any of the previous questions are marked, please explain:

_____

_____

_____

Please mark any of the following to indicate YES if you are currently taking or have taken any of the following medications:

☐ Alendronate-Fosamax-oral ☐ Ibandronate-Boniva-oral ☐ Risedronate-Actonel-oral

Family History

Has any member of your family had the following:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Sleep Disorder
- ☐ Obesity
- ☐ Thyroid Disorder
- ☐ Snores
- ☐ Wears CPAP
- ☐ Sleep Apnea

Medications:

List medications, dosages, the reason for taking medication:

_____

_____

_____

Allergies:

Please mark any of the following to indicate YES for allergy:

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Penicillin
- ☐ Iodine
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Sulfa
- ☐ Latex
- ☐ Other
- ☐ None

Do you have any other health issues or allergies?

_____

_____

Dental History

Please mark any of the following to indicate YES in response to the questions:

- ☐ Does your mouth function comfortably and harmoniously?
- ☐ Does your smile look exactly like you want it to?
- ☐ Are you fearful?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Are any of your teeth causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures or partials?

Your dental health is very important to us. Please indicate if you have experienced the following. Marking the box indicates a YES response. Leaving the box blank indicates a No response.

Posture:

- ☐ Back Pain
- ☐ Cervical Pain (upper neck)
- ☐ Facial Pain
- ☐ Lip or cheek biting
- ☐ Postural Problems
- ☐ Swelling in ankles or feet

Teeth:

- ☐ Braces: when_____
- ☐ Extracted teeth
- ☐ Blisters on lips or mouth
- ☐ Loose teeth
- ☐ Difficulty chewing
- ☐ Sensitivity to biting
- ☐ Dry mouth
- ☐ Bleeding gums
- ☐ Infected or swollen gums
- ☐ Diet limited to liquid or soft foods
- ☐ Receding gums
- ☐ Difficulty swallowing
- ☐ Bad breath
- ☐ Food collects between teeth
- ☐ Clenching teeth
- ☐ Poor fitting appliance
- ☐ Difficulty speaking
- ☐ Sensitivity to hot, cold or sweets

Jaw Joint:

- ☐ Clicking or popping jaw
- ☐ Jaw pain or tiredness
- ☐ Pain when swallowing
- ☐ Jaw joint noises
- ☐ Numbness in jawbone
- ☐ Jaw locks open
- ☐ Pain when chewing
- ☐ Headaches
- ☐ Morning head pain
- ☐ Pain around ear
- ☐ Grinding teeth
- ☐ Migraines
- ☐ Tingling in jawbone
- ☐ Ear congestion
- ☐ Limited opening
- ☐ Ringing in the ears
- ☐ Jaw locks closed

Sleep:

☐ CPAP intolerance ☐ Mouth breathing ☐ Daytime fatigue

☐ Nighttime choking spells ☐ Frequent heavy snoring ☐ Significant daytime drowsiness

☐ Gasping when waking up ☐ Sleepy while driving ☐ Morning hoarseness

Neurologic:

☐ Bell's Palsy ☐ Numbness in lower lip ☐ facial or trigeminal neuralgia

☐ Paresthesia of fingertips (tingling) ☐ Gagging easily ☐ Vertigo (dizziness)

☐ Muscle twitching

Other:

☐ Digestive problems ☐ Nutritional disorder ☐ Fingernail biting

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

Signature of patient, parent or guardian:

Signature_____ Date_____

Response Date:

_____/_____/_____

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Musculoskeletal Screening Questionnaire

Date_____
Name_____ Date of Birth _____
Address_____
Referred by_____

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas. (L = Left, R = Right)

A. Pain in jaw joint	___ L R___	O. Upset stomach-nausea	__ yes no ___
B. Pain in ear	___ L R___	P. Ringing sound in ears	___ L R___
C. Pain around eyes	___ L R___	Q. Headache	__ yes no ___
D. Pain in lower jaw	___ L R___		___ L R___
		R. Fullness, pressure blockage in ear	
E. Pain in upper jaw	___ L R___	S. Pain in the tongue	___ L R___
F. Pain in neck	___ L R___	T. Partial inability to open mouth If yes, is it 1. Constant ( ) 2. Sporadic ( )	__ yes no ___
G. Pain in shoulder	___ L R___	U. Difficulty chewing	__ yes no ___
H. Pain in forehead	___ L R___	V. Difficulty swallowing	__ yes no ___
I. Pain in temples	___ L R___	W. Loud snoring	__ yes no ___
J. Pain in facial muscles	___ L R___	X. Constantly tired	__ yes no ___
K. Grating sound in joint	___ L R___	Y. Mouth breathe at night	__ yes no ___
L. Clicking, snapping, or Popping sound in joint (underline which sounds most descriptive.) If present, is it in	___ L R___	Z. Awaken with a dry mouth If yes, a. Frequently ( ) b. Rarely ( ) c. Never ( )	__ yes no ___
M. Subjective hearing loss	___ L R___		
N. Dizziness (vertigo)	___ yes no ___		

1. What are your chief complaints? List from most to least important.

a. _____

b. _____

c. _____

Other symptoms (Please write in.)

_____

2. Do symptoms affect one or both joints? Right ( ) Left ( ) Both ( )

If both joints, indicate which joint seems most affected ____L ____R

3. How many years, months, weeks, or days have you been bothered by this problem?

_____

4. Have you had any injury to the jaw or face? ____yes ____no
5. Do you have arthritis? ____yes ____no
6. Have you ever had cervical traction? ____yes ____no
7. Have you ever worn a neck brace? ____yes ____no
8. Have you had any other treatment for this problem? ____yes ____no

(if yes, explain - medicine, exercise, dental appliances such as a splint, or night guard)

_____

9. Have you had your teeth straightened (orthodontia)? ____yes ____no
10. Have you had teeth removed for orthodontia? ____yes ____no
11. Have you had your wisdom teeth removed? ____yes ____no
12. Have you ever had general anesthesia? ____yes ____no
13. Did you have allergies as a child? ____yes ____no ____Unknown
14. Have you had your bite adjusted by your dentist (equilibration)? ____yes ____no

(if yes please explain when)

15. Do you attribute the symptoms to any one incident? ____yes ____no
    if yes please explain _____
16. Have you had cortisone injected into a joint? ____yes ____no
    If yes, when?_____ How many injections?_____
    By whom?_____
17. Are you now on any medications? ____yes ____no

If yes, what kind and how much? _____

18. Do you know if you clench your teeth? ____yes ____no
19. Has anyone mentioned that you grind your teeth (brux) at night during sleep? ____yes ____no
20. Do you chew gum?

Frequently ( ) Moderately ( )

Infrequently ( ) Never ( )

21. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on the back of this sheet if necessary.

    a. _____

    b. _____

    c. _____

    d. _____

    e. _____

22. Please write in any other pertinent information that has not been covered previously. Write on back of this sheet if necessary.

_____

_____

_____

_____

_____

23. Are you in litigation or are you planning litigation? ____yes ____no

    If so, explain _____

    _____

    _____

    _____

    _____

    _____

    _____

Head, Neck, and Facial Pain Questionnaire

Office use:

Patient ID:_____

NAME: First _____ Last _____ MI_____

DATE OF BIRTH: _____ ___MALE ___FEMALE

What are the chief complaints for which you are seeking treatment?

1. Please number your complaints with #1 being the most severe, #2 being the next most severe etc. 2.

Then rate your complaints for frequency and intensity

Frequency

1- Seldom 2-Occasional 3-Frequent 4- Everyday

Intensity

0=No pain and 10 is most severe pain

Number #1= the most severe symptom	**Frequency** 1-4	**Intensity** 1-10
_____ Difficulty swallowing	_____	_____
_____ Dizziness	_____	_____
_____ Facial pain	_____	_____
_____ Headaches	_____	_____
_____ Jaw clicking	_____	_____
_____ Jaw locking	_____	_____
_____ Jaw pain	_____	_____

Continued	**Frequency** 1-4	**Intensity** 1-10
_____ Morning hoarseness	_____	_____
_____ Morning headaches	_____	_____
_____ Nocturnal teeth grinding	_____	_____
_____ Facial pain	_____	_____
_____ Sleepy while driving	_____	_____

Other- write in:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Symptoms

MOUTH AND NOSE RELATED CONDITION

[L] [R] [B] Which side hits first when you bite down?
Do your teeth hit in the front or back first?
___yes ___no Front
___yes ___no Back

___yes ___no Broken teeth

___yes ___no Frequent biting of cheek

___yes ___no Frequent snoring

___yes ___no Gums bleeding after brushing

___yes ___no Gums bleed after flossing

JAW PAIN

[L] [R] [B] Jaw pain - at rest

[L] [R] [B] Jaw pain - on opening

[L] [R] [B] Jaw pain - while chewing

JAW SYMPTOMS

___yes ___no Jaw popping

[L] [R] [B] Jaw clicking

___yes ___no Teeth clenching

___yes ___no Teeth grinding

___yes ___no Jaw locks closed

___yes ___no Jaw locks open

EAR RELATED CONDITIONS

___yes ___no Pain in front of the ear

___yes ___no Ear congestion

___yes ___no Tinnitus (ringing in the ears)

___yes ___no Ear pain

___yes ___no Buzzing in the ears

___yes ___no Hearing loss

___yes ___no Recurrent ear infections

___yes ___no Dizziness

EYE RELATED CONDITIONS

___yes ___no Blurred vision
___yes ___no Eye pain
___yes ___no Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

___yes ___no Neck pain

___yes ___no Limited movement of neck

___yes ___no Swelling in the neck

___yes ___no Shoulder pain

___yes ___no Shoulder stiffness

___yes ___no Back pain-upper

___yes ___no Tingling in the hands or fingers

___yes ___no Chronic sinusitis

___yes ___no Swollen glands

STRESS RELATED CONDITIONS

___yes ___no Stress levels above normal?

___yes ___no Do you suffer from anxiety?

___yes ___no Do you suffer from insomnia?

___yes ___no Do you suffer from depression?

HEAD PAIN

___yes ___no Headaches

___yes ___no Migraines

___yes ___no Entire head (generalized)

[L] [R] [B] Front of your head (Frontal)

___yes ___no Top of head

[L] [R] [B] Back of your head

[L] [R] [B] In your temples

Other: _____

HISTORY OF SYMPTOMS

When did the pain or condition first occur? _____
What do you believe is the cause of the pain or condition? (choose ONE from below)
____ removal of wisdom teeth
____ removal of one tooth, right bottom and wearing an appliance
____ a motor vehicle accident
____ a motorcycle accident
____ a work-related incident
____ a playground incident
____ an athletic endeavor
____ a fight
____ a fall
____ an accident
____ an illness
____ an injury
____ unknown

Are your activities limited due to pain? ___yes ___no
Are you at the computer 4 or more hours per day? ___yes ___no
Is there anything that makes your pain or discomfort worse? _____
Is there anything that makes your pain or discomfort better? _____
What other information is important regarding the pain or condition? _____

LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

	Practitioner	Specialty	Treatment	(Approx.) Date
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____
11	_____	_____	_____	_____
12	_____	_____	_____	_____

HEAD PAIN HISTORY

Pain Qualities

Which side are the headaches worse? (Choose ONE from below)

___ both sides
___ the left side
___ the right side

Headaches spreads to (choose ONE from below)

___ the temple
___ the back of the head ___
the forehead

SEVERITY ON A SCALE OF 0-10
(0 being no pain at all and 10 being the worst pain imaginable)

___ Jaw pain on a 0-10 pain scale
___ Headaches on a 0-10 pain scale
___ Neck pain on a 0-10 pain scale
___ Facial pain on a 0-10 pain scale

FREQUENCY (choose ONE from below)
___ occasional
___ frequent
___ constant

DURATION
___ Yes ___ No seconds
___ Yes ___ No hours
___ Yes ___ No days
___ Yes ___ No weeks

When having pain do you experience:

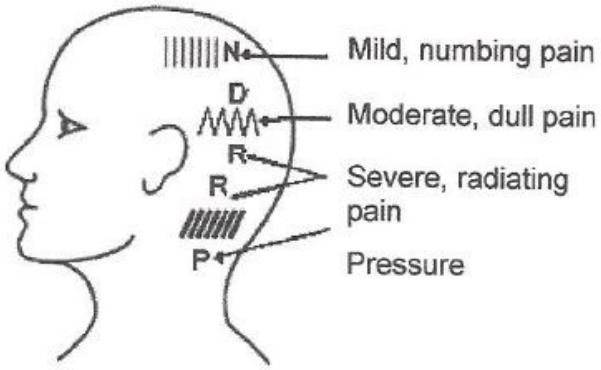
___Yes ___No Dizziness
___Yes ___No Double vision
___Yes ___No Fatigue
___Yes ___No Nausea
___Yes ___No Sensitivity to light (photophobia)
___Yes ___No Sensitivity to noise
___Yes ___No Throbbing
___Yes ___No Vomiting
___Yes ___No Burning

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

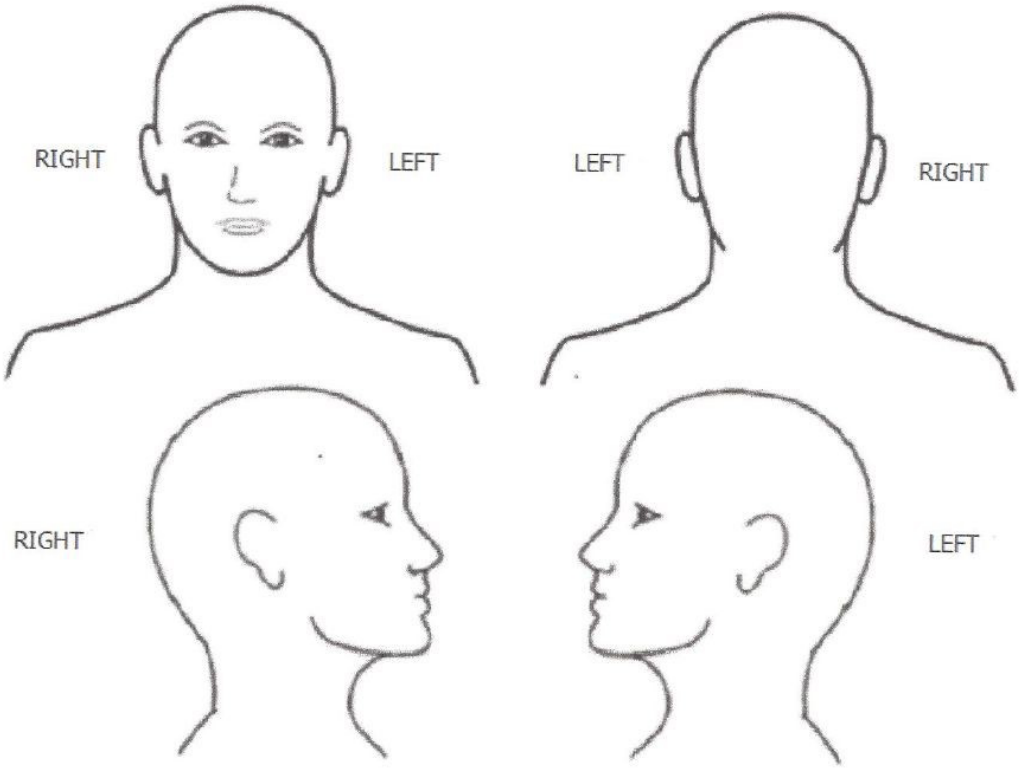
Mild Pain IIIII

Moderate Pain ΛΛΛ

Severe Pain //////



B - Burning
D - Dull
N - Numbing
P - Pressure
S - Sharp
T - Tingling
R - Radiating



Patient Signature _____ Date_____