



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

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Patient/Parent Signature \_\_\_\_\_ Today's Date \_\_\_\_\_



# TMJ QUESTIONNAIRE

Page 1 of 2

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 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 may 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 to be used for the purpose of research, education or publication in professional journals.

With any medical 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

Patient's Legal Name \_\_\_\_\_

Office Use Only

### 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**

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## 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 \_\_\_\_\_

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