Smiles for Life Dental Group

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

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. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

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

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

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial Pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Inability to open mouth	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Migraine Headaches	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
	Other - write in:		
____	_____	____	____
____	_____	____	____

Patient Signature

_____

Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other _____ _____
_____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other _____ _____
_____ _____

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

	Practitioner	Specialty	Treatment & approximate date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y☐ N☐ Adenoids Removed
Y☐ N☐ Tonsils Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐ High ☐ Low
Y☐ N☐ Bruising easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fluid retention
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ Fibromyalgia
Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Hypoglycemia

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Kidney problems
Y☐ N☐ Liver disease
Y☐ N☐ Meniere's disease
Y☐ N☐ Menstrual cramps
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle aches
Y☐ N☐ Muscle shaking (tremors)
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nervousness
Y☐ N☐ Neuralgia
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Ovarian cysts
Y☐ N☐ Parkinson's disease
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
☐ Frequent Colds
☐ Ear Infections
☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders
Y☐ N☐ Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN LOCATION	SEVERITY			FREQUENCY			DURATION				
	MILD	MODERATE	SEVERE	OCCASIONAL (MONTHLY OR LESS}	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

JAW PAIN

L R B Jaw pain - on opening
L R B Jaw pain - while chewing
L R B Jaw pain - at rest

JAW SYMPTOMS

Y☐ N☐ Jaw clicks
Y☐ N☐ Jaw locks closed
Y☐ N☐ Jaw locks open
Y☐ N☐ Jaw popping
Y☐ N☐ Teeth clenching
Y☐ N☐ Teeth grinding

EYE RELATED CONDITIONS

Y☐ N☐ Blurred vision
Y☐ N☐ Double vision
Y☐ N☐ Eye pain
Y☐ N☐ Pain or pressure behind the eyes
Y☐ N☐ Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

Y☐ N☐ Buzzing in the 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 RELATED CONDITIONS

Y☐ N☐ Back pain - lower
Y☐ N☐ Back pain - middle
Y☐ N☐ Back pain - upper
Y☐ N☐ Chronic sore throat
Y☐ N☐ Constant feeling of a foreign object in throat
Y☐ N☐ Difficulty in swallowing
Y☐ N☐ Limited movement of neck
Y☐ N☐ Neck pain
Y☐ N☐ Numbness in the hands or fingers

Patient Signature _____ Date _____

THROAT NECK & BACK RELATED CONDITIONS (Continued)

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 the hands or fingers
Y☐ N☐ Torticollis

MOUTH & NOSE RELATED CONDITIONS

Y☐ N☐ Broken teeth
Y☐ N☐ Burning tongue
Y☐ N☐ Chronic sinusitis
Y☐ N☐ Dry mouth
Y☐ N☐ Frequent biting of cheek
Y☐ N☐ Frequent snoring

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

_____

What do you believe is the cause of your pain or condition?

Pick one:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related incident ☐ Playground incident
☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Illness ☐ Injury
☐ Unknown ☐ Other _____

If accident, date _____

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 to your pain or condition? _____

_____

FAMILY HISTORY

Have any members of your family (blood kin) had: Y☐ N☐ Headaches Y☐ N☐ High blood pressure
Y☐ N☐ Heart disease Y☐ N☐ Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y☐ N☐ If yes, how many children? _____ What are their ages? _____

Y☐ N☐ Are you currently under unusual stress?
Y☐ N☐ Recent change in lifestyle?
Y☐ N☐ Do you exercise regularly?

Y☐ N☐ Do you chew tobacco?
Number of caffeine drinks per day _____

Y☐ N☐ Do you smoke?

_____ *Number of* ☐ Packs ☐ Cigarettes *per* ☐ Day ☐ Week

Alcohol consumption

☐ None ☐ Social Drinker
☐ Occasional ☐ Daily

Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

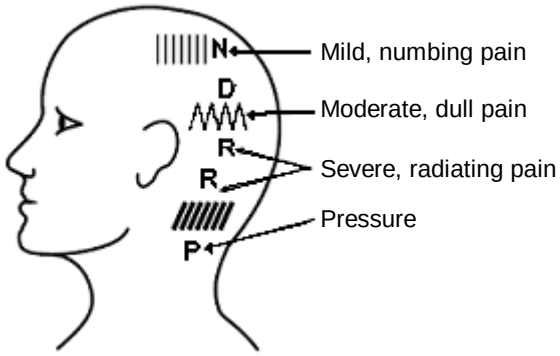
MILD PAIN

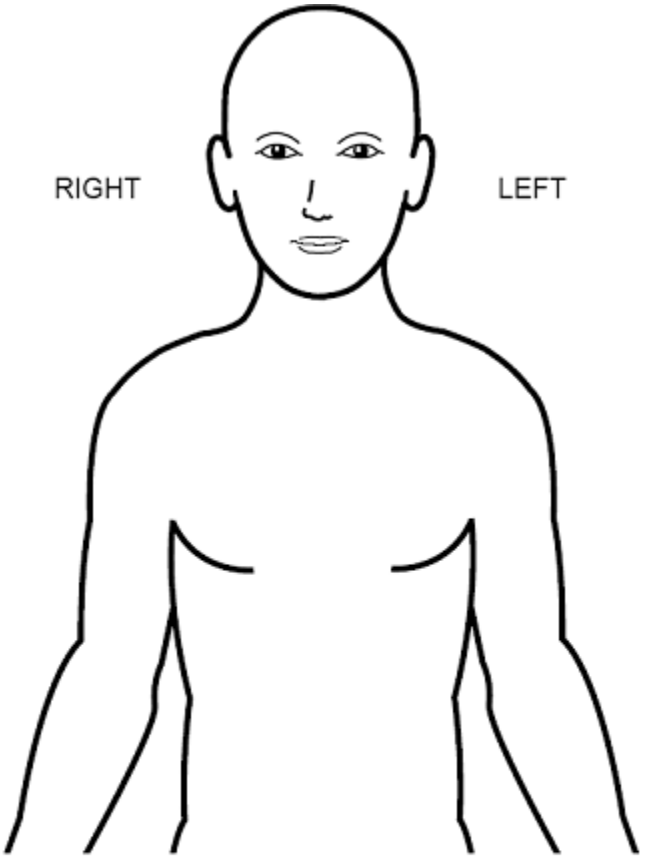
MODERATE PAIN

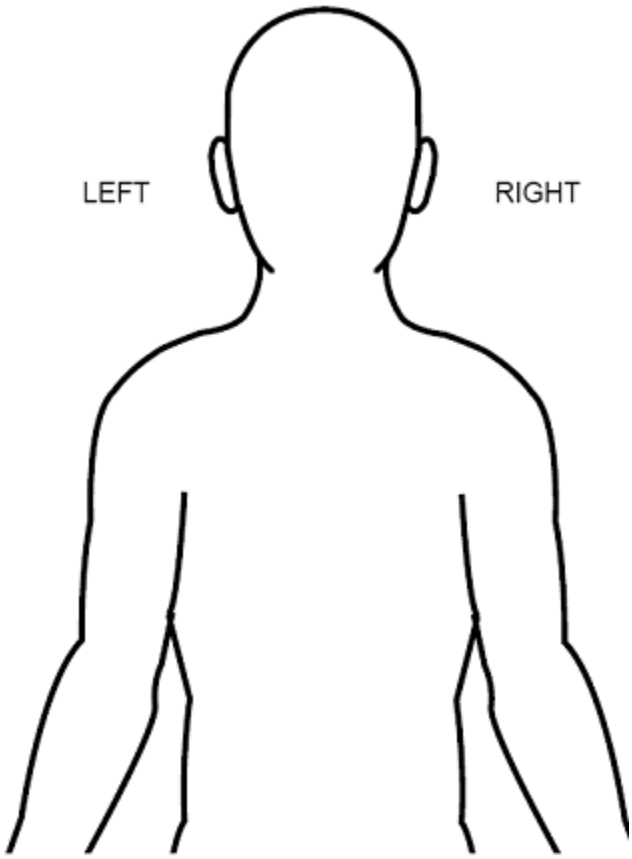
SEVERE PAIN

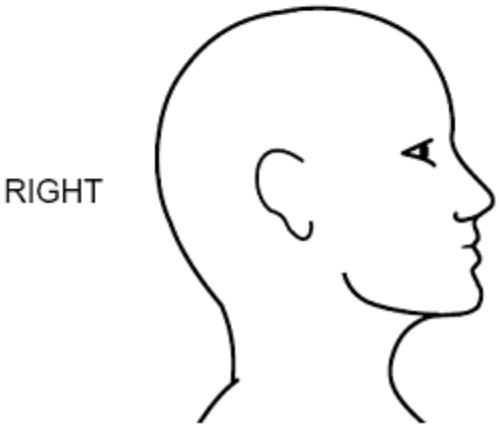
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

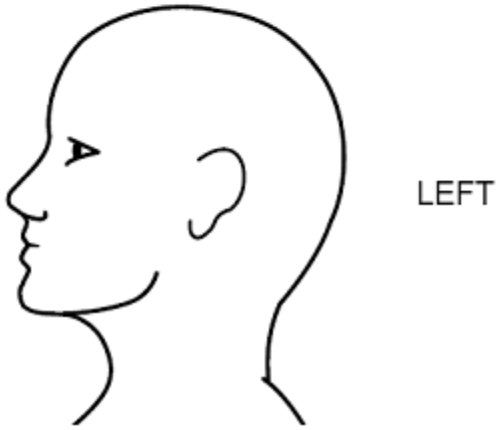
EXAMPLE











Patient Signature _____ Date _____

HISTORY OF ACCIDENT

IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ? (Choose one)

- ☐ A passenger in a vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work

AND... (Choose one)

- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- ☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- ☐ At front end
- ☐ At rear end
- ☐ At front right area
- ☐ At front left area
- ☐ At rear right area
- ☐ At rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- ☐ Other _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA.

DID YOUR

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- ☐ Other _____

FORCIBLY STRIKE

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Interior of car
- ☐ Other _____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back
- ☐ Other: _____

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

_____

DID YOU GO TO THE HOSPITAL? ☐ Yes ☐ No ☐ By Car ☐ By Ambulance

☐ TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU ☐ SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

HAS A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

☐ Yes ☐ No If yes, please explain _____

_____

Patient Signature _____ Date _____

IF YOU HAD A PREVIOUS ACCIDENT, PLEASE GIVE AN ACCURATE DESCRIPTION, _____

_____

_____ INCLUDING DATE: _____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE TREATED FOR THIS PREVIOUS ACCIDENT: _____

_____

_____

IF YOU HAVE MISSED ANY WORK PLEASE GIVE DATES: _____

_____

INSURANCE INFORMATION

AUTO INSURANCE

Please mark each insurance category

☐ your insurance ☐ driver of vehicle's insurance ☐ other vehicle's insurance ☐ owner of vehicle's insurance

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____ Insured's Birth date. _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Claim No. _____ Has this been reported? ☐ Yes ☐ No

OTHER TYPES OF INSURANCE

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____ Insured's Birth date. _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No _____

WORKER'S COMPENSATION

Employee _____

Address _____

City, State, Zip _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? ☐ Yes ☐ No If yes, was treatment authorized? _____

Insurance Co. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No _____ Group No. _____ I.D. No. _____

If you have additional insurance, please enter the information on the reverse side of this form.

Patient Signature _____ Date _____

ATTORNEY INFORMATION

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

Attorney's Name _____ Paralegal _____ Phone No. _____

Address _____

City, State, Zip _____

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

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Insurance Company _____

☐ Group Health ☐ Auto ☐ Government ☐ Self Insured ☐ Dental

Contact Person _____

Effective date of this policy _____ TMJ policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Is there a policy maximum for TMJ disorders? _____

Is precertification required _____

Can benefits be assigned to doctor? ☐ Yes ☐ No

What information is needed to process the claim? _____

_____

_____

For No Fault: Amount of benefits _____

Mailing Address _____

City, State, Zip _____

Adjuster _____ Assignment approved ☐ Yes ☐ No

By _____

Other: _____

_____

_____

_____

Patient Signature _____ Date _____

Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ CURRENT DATE: __/__/____
First *Middle Initial* *Last*

DATE OF BIRTH: _____ ☐MALE ☐FEMALE

Referring Physician: _____

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

1. Please **number** your complaints with #1 being the most severe, #2 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**
____	CPAP intolerance	____	____
____	Difficulty falling asleep	____	____
____	Fatigue	____	____
____	Frequent heavy snoring	____	____
____	Frequent heavy snoring which affects the sleep of others	____	____
	Other - Write in:		
____	_____	____	____
____	_____	____	____
____	_____	____	____

Continued...		**Frequency** **1-4**	**Intensity** **1-10**
____	Gasping when waking up	____	____
____	Nighttime choking spells	____	____
____	Significant daytime drowsiness	____	____
____	Sleepiness while driving	____	____
____	Witnessed apneic events	____	____
____	_____	____	____
____	_____	____	____
____	_____	____	____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situatons?

✓ **Check one in each row:**	**0 No chance of dozing**	**1 Slight chance of dozing**	**2 Moderate chance of dozing**	**3 High chance of dozing**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

Patient Signature _____ Date _____

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

☐ Home Sleep Study ☐ Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of
[ ] moderate obstructive sleep apnea
[ ] severe obstructive sleep apnea
[ ] mild obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	____	____	____	____
an AHI of	____	____	____	____

a nadir SpO2 of ____ T90 ____ ODI (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None
REM Sleep ☐ Decreased ☐ None

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

__Yes __No Mask leaks
__Yes __No Inability to get the mask to fit properly
__Yes __No Discomfort from headgear
__Yes __No Disturbed or interrupted sleep
__Yes __No Noise disturbing sleep and/or bed partner's sleep
__Yes __No CPAP restricted movements during sleep
__Yes __No CPAP does not seem to be effective
__Yes __No Pressure on the upper lip causing tooth related problems
__Yes __No Latex allergy
__Yes __No Claustrophobic associations
__Yes __No An unconscious need to remove the CPAP
__Yes __No Does not resolve symptoms
__Yes __No Noisy
__Yes __No Cumbersome

Other _____ _____ _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

__Yes __No Dieting
__Yes __No Weight loss
__Yes __No Surgery (Uvuloplasty)
__Yes __No Surgery (Uvulectomy)
__Yes __No Pillar procedure
__Yes __No Smoking cessation
__Yes __No CPAP
__Yes __No BiPap
__Yes __No Uvulectomy (but continues to have symptoms)
__Yes __No Uvuloplasty (but continues to have symptoms)

Other _____

_____

Patient Signature _____ Date _____

SLEEP HISTORY

Previous Diagnosis

☐ Yes ☐ No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? _____ ☐ Years ago ☐ Months ago ☐ Days ago
number

Sleep:

How long does it take you to fall asleep? ____ minutes

Normally goes to bed at ___ ☐ AM ☐ PM

Hours of sleep per night ___ hours

Sleep aid ☐ Yes ☐ No

If yes, name that medication _____

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
_____ Getting up <number of times> per night
__Yes __No Hypnagogic Hallucinations
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks discussed ☐ Yes ☐ No

The patient:

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches

_____ Naps
_____ (Choose ONE from below)
_____ naps daily
never naps
occasionally naps

Snoring is reported as:

_____ Frequency
_____ (Choose ONE from below)
_____ seldom
_____ never
daily
often

_____ Severity
_____ (Choose ONE from below)
_____ light
moderate
loud

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____