

**JOHN J. TADDEY, DDS
7946 IVANHOE AVE #107
LA JOLLA, CA 92037
(858) 454-9333**

Welcome! So that we may provide you with the best possible TMJ care, please complete this entire medical/dental history form. All information is completely confidential.

PATIENT'S FULL NAME: _____ **DOB:** _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

HOME PHONE: _____

EMPLOYER: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

WORK PHONE: _____

DRIVER'S LICENSE #: _____ **SOCIAL SECURITY#:** _____

SPOUSE OR PARENT'S NAME: _____ **DOB:** _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

HOME PHONE: _____

EMPLOYER: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

WORK PHONE: _____

DRIVER'S LICENSE #: _____ **SOCIAL SECURITY #:** _____

*******TMJ PATIENT ONLY*******

INSURANCE COMPANY (MEDICAL): _____

ADDRESS: _____

PHONE #: _____

POLICY #: _____

GROUP #: _____

INSURED: _____

****QUESTIONNAIRE FOR FACIAL-PAIN & TMJ DYSFUNCTION****

1. PATIENT NAME _____ AGE _____
2. ADDRESS _____ CITY _____ ZIP _____
3. HOME PHONE # _____ OFFICE # _____
4. REFERRED BY _____
5. DO YOU HAVE HEADACHES? _____ NECK PAIN? _____ JAW PAIN? _____
FACE PAIN? _____ OTHER? _____
WHICH SIDE HURTS RIGHT? _____ LEFT? _____ BOTH? _____
6. WHEN DID YOU FIRST NOTICE PAIN? _____
7. IS THE PAIN CONSTANT? _____
BURNING? _____ STABBING? _____ OTHER? _____
WORSE IN THE MORNING? _____ WORSE IN THE AFTERNOON? _____
8. DOES IT HURT TO CHEW? _____ OPEN WIDE? _____
9. DOES YOUR JAW MAKE A POPPING NOISE? _____
CLICKING? _____ GRINDING? _____ OTHER? _____
10. HAS YOUR JAW EVER "LOCKED" OR SLIPPED OUT OF PLACE? _____
11. DO YOU EVER CLENCH OR GRIND YOUR TEETH? _____
DURING THE DAY? _____ DURING THE EVENING? _____
12. DO YOU HAVE PROBLEMS WITH YOUR EARS? _____ RINGING? _____
HEARING? _____ CLOGGED? _____ DIZZINESS? _____ PAIN? _____
13. IS IT DIFFICULT TO SWALLOW? _____
14. ARE YOUR TEETH SORE OR SENSITIVE? _____
15. ARE YOU TAKEN MEDICATION OF ANY KIND? _____
FOR WHAT REASON? _____
16. DO ANY OF OTHER JOINTS IN YOUR BODY CAUSE YOU DIFFICULTIES? _____
17. HAS THERE BEEN A CHANGE IN YOUR STRESS LEVEL SINCE THE
SYMPTOMS BEGAN? _____
18. HAS YOUR SLEEPING PATTERN CHANGE? _____
19. DO YOU SLEEP ON YOUR STOMACH? _____ BACK? _____
SIDE? _____ PILLOW TOP? _____
20. PLEASE DESCRIBE YOUR DIFFICULTY IN YOUR OWN WORDS? _____

21. PLEASE LIST ALL HEALTH CARE PROFESSIONALS FROM WHOM YOU
HAVE RECEIVED TREATMENT FOR THIS CONDITION: _____

22. DO YOU HAVE ANY FEELINGS OR WEAKNESS OF NUMBNESS?

23. ARE YOU UNDER A GREAT DEAL OF STRESS?

24. HAS ANY TREATMENT HELPED YOUR CONDITION?
PLEASE EXPLAIN? _____

25. HAS YOUR LIFE STYLE CHANGED SINCE THIS CONDITION BEGAN? _____
IN WHAT MANNER? _____

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TEMPOROMANDIBULAR JOINT DYSFUNCTION

**NOTICE OF FINANCIAL
RESPONSIBILITY**

While most major medical carriers will generally provide coverage for a part of your TMJ therapy, insurance policies may vary as to their provision and exclusion.
(THEREFORE, THIS OFFICE CAN NOT BEGIN TREATMENT UNTIL FINANCIAL ARRANGEMENTS HAVE BEEN AGREED TO.)

We suggest that you review your medical insurance policy, or “benefits booklet” so that you may be made aware of the specific limitations of your major medical contract.

You will be required to provide the major medical insurance claim form, which can be obtained through your employer, union, or the agent for your group policy.

This office will assist you in completing your insurance claim form, and will provide all of the additional information required to process the claim. However, it will be your responsibility to pursue payment from the insurance carrier if payment is not received promptly.

Again, we advise you to read your policy carefully and to contact your insurance carrier if you have any questions regarding your coverage for TMJ services.

Thank you for your cooperation.

Patient Signature

Date