IKC ORTHODONTICS
Live Well. Bite Right. Smile Always.

TMD NEW PATIENT

PATIENT INFORMATION

DATE: _____

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DATE OF BIRTH: _____ AGE: _____ I IDENTIFY MY GENDER AS: _____

ADDRESS: _____

APARTMENT #: _____CITY: _____ POSTAL CODE: _____

ADULTS:

EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: _____

MINORS:

PATIENT LIVES WITH: MOTHER_____ FATHER: _____ BOTH: _____ OTHER: _____

GUARDIAN #1 RELATIONSHIP TO PATIENT: _____ NAME: _____

BEST TELEPHONE CONTACT NUMBER: _____ **PLEASE CIRCLE:** HOME CELL WORK

EMAIL: _____

GUARDIAN #1 RELATIONSHIP TO PATIENT: _____ NAME: _____

BEST TELEPHONE CONTACT NUMBER: _____ **PLEASE CIRCLE:** HOME CELL WORK

WHO REFERRED YOU TO OUR OFFICE? _____

NAME OF CURRENT DENTIST: _____ PHONE NUMBER: _____

DENTIST ADDRESS: _____

LAST VISIT AT THEIR OFFICE: _____ REASON: _____

NAME OF PHYSICIAN: _____ PHONE NUMBER: _____

OTHER FAMILY MEMBERS TREATED AT OUR OFFICE: _____

DO YOU HAVE INSURANCE? IF YES, PLEASE FILL OUR BELOW:

FIRST AND LAST NAME OF POLICY HOLDER: _____DATE OF BIRTH: _____

NAME OF INSURANCE COMPANY: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

WHAT IS THE CHIEF COMPLAINT THAT YOU ARE SEEKING TREATMENT FOR?

PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY FROM #2 - #9

	Recent	Chronic
_____ Headache Pain	____	____
_____ Ear Pain	____	____
_____ Jaw Pain	____	____
_____ Facial Pain	____	____
_____ Eye Pain	____	____
_____ Throat Pain	____	____
_____ Neck Pain	____	____
_____ Shoulder Pain	____	____
_____ Back Pain	____	____
_____ Limited Ability to Open Mouth	____	____
_____ Jaw Joint Locking	____	____
_____ Jaw Joint Noises	____	____
_____ Ear congestion	____	____
_____Sinus Congestion	____	____
_____ Dizziness	____	____
_____ Tinnitus (ringing in ears)	____	____
_____Muscle Twitching	____	____
_____ Vision Problems	____	____

	Recent	Chronic
_____ Kicking or jerking leg	____	____
_____ Swelling in ankles or feet	____	____
_____ morning hoarseness	____	____
_____ Dry mouth upon waking	____	____
_____ fatigue	____	____
_____ Difficulty falling asleep	____	____
_____ Tossing and Turning Frequently	____	____
_____ Repeated awakening	____	____
_____ Unrefreshed in the morning	____	____
_____ Significant daytime drowsiness	____	____
_____ Frequent heavy snoring	____	____
_____ Affects sleep of others	____	____
_____ Gasping when waking	____	____
_____ “Stop breathing” during sleep	____	____
_____Night-time choking spells	____	____
_____ Unable to tolerate C-Pap	____	____
_____ Tooth Grinding	____	____
_____ Teeth Crowding	____	

OTHER:_____

_____

DO YOU HAVE ANY OTHER CONCERNS IN THESE AREAS?

_____ GENERAL APPEARANCE _____ OVERBITE _____ ABILITY TO FUNCTION _____ SMILE

OTHER COMMENTS: _____

DO ANY OF THESE CONCERNS AFFECT YOUR DAILY LIFE? _____

WHAT ARE THE RESULTS YOU ARE SEEING FROM TREATMENT? _____

PATIENT SIGNATURE: _____ DATE: _____

MEDICAL FORM:

DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES?

☐ ANESTHETICS	☐ CODINE	☐ PENICILLIN
☐ ANTIBIOTICS	☐ IODINE	☐ PLASTIC
☐ ASPRIN	☐ LATEX	☐ SEDATIVES
☐ BARBITUATES	☐ METALS	☐ SULFA

OTHER: _____

_____

_____

_____

_____

CURRENT MEDICATIONS: Please list all current medications and reasons you are taking them. Please include over the counter medications, vitamins, herbs, etc.

_____

_____

_____

_____

_____

_____

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING: (Botox, orthotics, massage, etc.)

_____

_____

_____

_____

_____

_____

HEALTH AND MEDICAL HISTORY:

ARE YOU PREGNANT? ☐ YES ☐ NO

HAVE YOU SUSTAINED AN UNJURY TO: ☐ HEAD ☐ NECK ☐ FACE ☐ TEETH ☐ OTHER: _____

DO YOU DRINK 4 OR MORE CUPS OF COFFEE A DAY? ☐ YES ☐ NO

DO YOU SMOKE TOBACCO? ☐ YES ☐ NO

DO YOU CONSUME ALCOHOL OR TAKE SEDATIVES? ☐ YES ☐ NO

HAVE YOU HAD ANY PREVIOUS ORTHODONTIC TREATMENT? ☐ YES ☐ NO

TROUBLE BREATHING THROUGH YOUR NOSE? ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

MEDICAL FORM (continued):

- ☐ Heart Disorder/ Heart Attack
- ☐ Heart Murmur
- ☐ Mitral Valve Prolaps
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Irregular Heartbeat
- ☐ Blood Pressure – High ☐ Low ☐
- ☐ Stroke
- ☐ Bleeding Easily
- ☐ Bruising Easily
- ☐ Cancer of _____
- ☐ Chemo ☐ Radiation ☐
- ☐ Anemia
- ☐ Asthma
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gastroesophageal Reflex (Gerd)
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Psychiatric Care
- ☐ Sinus Problems
- ☐ Speech Difficulties
- ☐ History of Substance Abuse
- ☐ Hypoglycemia
- ☐ Huntington's Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Migraines
- ☐ Meniere's Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuralgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Intestinal Disorder
- ☐ Nervous System Disorder
- ☐ Anxiety
- ☐ Skin Disorder
- ☐ Recent Weight Gain
- ☐ Shortness of Breaths
- ☐ Swollen, Stiff or Painful Joints
- ☐ Urinary Tract Disorder
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Cold Hands and Feet
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Difficulty Breathing at night for sleep
- ☐ Dizziness
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fluid Retention
- ☐ Frequent Colds/Flu
- ☐ Frequent Coughs
- ☐ Frequent Ear Infections
- ☐ Frequent Sore Throat
- ☐ Hearing Impairment
- ☐ Memory Loss
- ☐ Hay Fever
- ☐ Insomnia
- ☐ Muscle Aches
- ☐ Muscle Spasms
- ☐ Muscle Tremors
- ☐ Poor Circulation
- ☐ Recent Weight Loss
- ☐ Slow Healing Sores
- ☐ Tired Muscles

Additional Information: _____

SURGICAL HISTORY:

GENERAL ANESTHESIA ☐ YES ☐ NO

ADNOIDS REMOVED ☐ YES ☐ NO

TONSILS REMOVED ☐ YES ☐ NO

JAW JOINT SURGERY ☐ YES ☐ NO

ORTHOGNATHIC SURGERY ☐ YES ☐ NO List: _____

OTHER SURGERY ☐ YES ☐ NO List: _____

PATIENT SIGNATURE: _____ **DATE:** _____

Head Pain

Location	Area	Recent	Chronic	Severity	Duration	Frequency
☐ Left ☐ Right ☐ Bilateral	Frontal (Forehead)	◯	◯	☐ Mild ☐ Moderate ☐ Severe	☐ Minutes ☐ Hours ☐ Days	☐ Occasional ☐ Frequent ☐ Constant
☐ Left ☐ Right ☐ Bilateral	Generalized	◯	◯	☐ Mild ☐ Moderate ☐ Severe	☐ Minutes ☐ Hours ☐ Days	☐ Occasional ☐ Frequent ☐ Constant
☐ Left ☐ Right ☐ Bilateral	Parietal (Top of head)	◯	◯	☐ Mild ☐ Moderate ☐ Severe	☐ Minutes ☐ Hours ☐ Days	☐ Occasional ☐ Frequent ☐ Constant
☐ Left ☐ Right ☐ Bilateral	Occipital (Back of Head)	◯	◯	☐ Mild ☐ Moderate ☐ Severe	☐ Minutes ☐ Hours ☐ Days	☐ Occasional ☐ Frequent ☐ Constant
☐ Left ☐ Right ☐ Bilateral	Temporal (Temple area)	◯	◯	☐ Mild ☐ Moderate ☐ Severe	☐ Minutes ☐ Hours ☐ Days	☐ Occasional ☐ Frequent ☐ Constant

Do you have any discomfort in the following areas? If so, please indicate when the pain began.

Jaw Pain
☐ Left ☐ Right Jaw Pain with Opening
☐ Left ☐ Right Jaw Pain when chewing
☐ Left ☐ Right Jaw Pain at Rest

Jaw locking
☐ Left ☐ Right Jaw locks open
☐ Left ☐ Right Jaw locks closed

Eye Related Conditions
☐ Left ☐ Right Blurred Vision
☐ Left ☐ Right Double Vision
☐ Left ☐ Right Eye Pain

Ear Related Conditions
☐ Left ☐ Right Buzzing in the Ears
☐ Left ☐ Right Ear Congestion
☐ Left ☐ Right Ear Pain
☐ Left ☐ Right Hearing Loss
☐ Left ☐ Right Itchiness or Stuffiness in ears

Throat Related Conditions
☐ Left ☐ Right Chronic sore Throat
☐ Left ☐ Right Difficulty Swallowing
☐ Left ☐ Right Swollen Glands

Jaw Joint Sounds
☐ Left ☐ Right Jaw sounds with opening
☐ Left ☐ Right Jaw sounds when chewing
☐ Left ☐ Right Jaw sounds at rest

Jay Joint Symptoms
☐ Left ☐ Right Teeth Clenching
☐ Left ☐ Right Teeth Grinding
☐ Left ☐ Right Pain or pressure behind eyes
☐ Left ☐ Right Extreme Sensitivity to light
☐ Left ☐ Right Wear of Glasses or Contact Lenses
☐ Left ☐ Right Pain Behind the Ear
☐ Left ☐ Right Pain in Front of Ear
☐ Left ☐ Right Recurrent Ear Infections
☐ Left ☐ Right Ringing in the Ear
☐ Left ☐ Right Thyroid Enlargement
☐ Left ☐ Right Tightness of Throat
☐ Left ☐ Right Constant Feeling of a Foreign Object in Throat
☐ Left ☐ Right Numbness in Hands or Fingers
☐ Left ☐ Right Swelling in the Neck

Neck Related Conditions
☐ Left ☐ Right Limited Movement of Neck
☐ Left ☐ Right Neck Pain

PATIENT SIGNATURE: _____ **DATE:** _____

Shoulder Related Conditions

☐ Left ☐ Right Shoulder Pain

☐ Left ☐ Right Shoulder Stiffness

☐ Left ☐ Right Tingling in Hands

Back Related Conditions

☐ Left ☐ Right Back Pain - Lower

☐ Left ☐ Right Back Pain – Middle

☐ Left ☐ Right Back Pain - Upper

☐ Left ☐ Right Sciatica

☐ Left ☐ Right Scoliosis

Mouth and Nose Related Conditions

☐ Left ☐ Right Dry Mouth

☐ Left ☐ Right Chronic Sinusitis

☐ Left ☐ Right Frequent Snoring

☐ Left ☐ Right Burning Tongue

☐ Left ☐ Right Broken Teeth

☐ Left ☐ Right Frequent Biting of the Cheek

Sleep Related Conditions

Sleep Position: ☐ side ☐ Back ☐ Stomach

Is it easy to fall asleep? _____

Do you feel rested upon waking? _____

Stopped breathing during sleep? _____

Average hours of sleep per night? _____

Do you wake often during the night? _____

How many times do you wake? _____

Gasping or choking during sleep? _____

Have you ever had a sleep study? _____

Where was the sleep study done? _____

When was the sleep study done? _____

History of Symptoms

On what date did symptoms first occur? _____

Do any family members have the same or similar problems? If yes, please explain _____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

IF YES, PLEASE COMPLETE A TRAUMA HISTORY FORM. WHICH WILL BE PROVIDED TO YOU AT YOUR APPOINTMENT.

Continued Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

I AUTHORIZE THE RELEASE OF ALL EXAMINATION FINDINGS AND DIAGNOSIS, REPORT AND TREATMENT PLANS ETC. TO ANY REFERRING OR TREATING HEALTH CARE PROVIDER. I ADDITIONALLY AUTHORIZE THE RELEASE OF ANY MEDICAL INFOMRATION TO INSURANCE COMPANIES, OR FOR LEGAL DOCUMENTATION TO PROCESS CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR MY TREATMWNR REGARDLESS OF INSURANCE COVERAGE.

PATIENT SIGNATURE: _____ DATE: _____

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Dr. Iris Kivity-Chandler

The Personal Information Protection & Electronic Document Act

The Canadian government now requires that we have your permission to collect your personal dental and medical information. This information will be used to assess your oral needs and advise you of treatment options. It will allow us to maintain communication with you and to communicate with your dentist, physician and other health care providers as well as provide insurance claim forms and treatment estimates. As well, your personal information can be used for teaching, demonstration purposes on an anonymous basis. Your personal information can also be used to process payments and collect unpaid accounts. Your photos may also be used on an anonymous basis for marketing purposes. All this information will be kept private and confidential; it will be accessible to you upon request.

I give permission to Dr. Kivity-Chandler to collect, use and disclose personal information about _____ for the purposes indicated.

Signature: _____

Print Name: _____

Date: _____

Witness Signature: _____

Print Name: _____

Date: _____

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X-Ray Release Authorization

Patient Name: _____
Date of Birth: ____ / ____ / _____ (mm/dd/yyyy)

Facility Information (Releasing Party):

Facility Name: _____

Address: _____

Phone Number: _____

Release To:
Dental/Medical Office: **Dr. Kivity-Chandler at IKC ORTHODONTICS**

Type of X-Rays:
☐ Bitewings ☐ Panoramic ☐ Full Mouth Series ☐ Other: _____

Delivery Method:
Email to: info@IKCortho.com

Authorization:
I authorize the release of these dental images and release the dental office from liability once the records are transferred as directed.

Patient/Parent Signature: _____
Date: ____ / ____ / _____

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