Facial Pain Dysfunction Evaluation

PERSONAL INFORMATION

First Name
-

Middle Name
-

Last Name
-

Date of Birth
-

Age
-

Gender
-

Home Phone
-

Mobile Phone
-

Work Phone
-

Street Address
-

Street Address 2
-

City
-

State
-

ZIP Code
-

Email
-

Patients Social Security Number
-

Driver's License
-

Marital Status
-

Occupation
-

Employer Name
-

Person to contact in case of Emergency
-

Relationship
-

Phone #
-

Person responsible for this account
-

Relationship
-

Who referred you to this office?
-

Phone #
-

INSURANCE INFORMATION

Policy Holder Name
-

Birthdate
-

Policy Holder Social Security Number
-

Address
-

Phone #
-

Medical Insurance Company
-

Insurance ID
-

Group/Policy #
-

CURRENT PROBLEM

In your own words, describe your present problem.
-

When did your problem start?
-

What do you feel caused your problem to start?
-

Describe the difference in your symptoms now and when they first began.
-

HEALTH HISTORY

Are you in good health?
-

Date of last physical exam
-

Are you under the care of a physician now?
-

Why?
-

Have you ever been hospitalized?
-

If yes, please briefly explain:
-

Have you ever had a serious illness?
-

If yes, please briefly explain:
-

Do you wear a cardiac pacemaker?
-

Are you pregnant?
-

Do you smoke or drink alcohol?
-

If yes, how much per day?
-

Do you exercise regularly?
-

How?
-

Does it affect your pain?
-

Do you have trouble getting to sleep or staying asleep?
-

Do you snore?
-

Please check any of the following which you presently have or have had in the past:

☐Blood disease	☐Oral ulcers	☐Heart disease	☐Hepatitis
☐Sinus problems	☐High blood pressure	☐Kidney disease	☐Arthritis
☐Respiratory disease	☐Tumors	☐Head injuries	☐Radiation treatment
☐Stomach ulcers	☐Nervous disorders	☐Diabetes	☐Chemotherapy
☐Epilepsy	☐Asthma	☐Mental disorders	☐Thyroid disease
☐Fainting spells	☐Seizures	☐Marked weight change	☐Night sweats
☐Skin rashes	☐Loss of hearing	☐Stroke	☐Depression
☐Loss of energy	☐Osteoporosis	☐Hormonal problems	

List all medication you are ALLERGIC to:
-

List the name and dose of All medication you now take (example: Prozac 20mg., 2x/day, am/pm) (If you have tried or used other meds and need more space: download Medication History) (Name of Medication) (Amount(mg)) (Number of doses per day)
-

Is there any disease, accidents, traumatic events or contributing factors that you think could be associated with your chief complaint that I should know about? If yes, please briefly explain:
-

List any change in occupation, residence, relationships, life style, financial status, divorce, separation, death, emotional distress, changes or new medications which may have occurred just before or during the time of your problem.
-

TEMPOROMANDIBULAR JOINT SYMPTOMS

Check if any of the following increase your pain:

☐Opening mouth	☐Closing mouth	☐Yawning	☐Eating
☐Talking	☐Moving jaw side to side	☐Moving jaw forward	☐Clenching teeth together
☐Turning head L or R	☐Looking up/looking down	☐Singing	☐Bending over
☐Hot/cold inside or outside mouth	☐Weather changes	☐Massage	☐Exercise
☐Sleep	☐Lying down	☐Sitting up or standing after lying	

Check any of the following that relate to your current problem:

☐Headaches	☐Neckaches	☐Ear pain	☐Ringing in ears
☐Fullness in ears	☐Eye pain	☐Dizziness	☐Frequent stress
☐Chronic fatigue	☐Nausea/vomiting	☐Poor sleep	☐Tooth pain
☐Finger numbness	☐Visual changes	☐Jaw locking	☐Hard to swallow
☐Sore throat	☐Upper back pain	☐Lower back pain	☐Clenching/grinding teeth
☐Jaw noises	☐Difficult to open/close mouth	☐Teeth don't feel like they fit together	☐Jaw joint pain
☐Facial pain	☐Facial burning	☐Facial numbness	☐Facial swelling

Does your jaw make NOISE?
-

Are the noises on your left or right side?
-

When did you first notice these noises?
-

Is there pain when your jaw makes these noises?
-

Has the noise changed since you first noticed it?
-

-

Has your jaw ever LOCKED OPEN or CLOSED?
-

How often?

☐ Daily ☐ Weekly ☐ Monthly

When was the last time this happened?
-

What is the longest it has stayed locked?

☐ Seconds ☐ Minutes ☐ Hours ☐ Days

HEADACHE SYMPTOMS

Do you suffer from headaches?

☐ Yes ☐ No

Where do your headaches most often occur?

☐ Temples ☐ Eyes ☐ Forehead ☐ Back of head
☐ Neck ☐ Other

If you selected other, please briefly explain:
-

How often do they occur?

☐ Daily ☐ Weekly ☐ Monthly

When are they worst?

☐ during the night ☐ waking up ☐ afternoon/evening

Do you take medication for your headache?
-

If you answered yes, please list all medications you are currently taking for your headaches:
-

Check any of the following which occur with your headache

☐ Nausea ☐ Vomiting ☐ Visual changes ☐ Confusion
☐ Burning ☐ Numbness ☐ Sweating ☐ Paralysis
☐ Eye Tearing ☐ Throbbing ☐ Sensitivity to light

Check any of the following which may start your headache:

☐ Stress ☐ Tension ☐ Exercise ☐ Fatigue
☐ Sleep ☐ Body positions ☐ Head positions ☐ Time of Day
☐ Time of month ☐ Time of year ☐ Jaw movements ☐ Certain foods

PAIN SCALE

Please mark your current pain level:

☐0 - Pain Free	☐1 - Mild, pain is barely noticeable, most of the time you dont think about it.	☐2 - Minor, annoying and may have occasional stronger twinges	☐3 - Uncomfortable, pain is noticeable and distracting, however you can get used to it and adapt
☐4 - Moderate, if you are deeply involved in an activity, it can be ignored for a period of time but is still distracting	☐5 - Distracting, moderately strong pain. It can be ignored for a few moments but with effort you still can manage to work or participate in some activities	☐6 - Distressing, moderately strong pain that interferes with normal daily activities and causes difficulty concentrating	☐7 - Severe, pain that dominates your senses and significantly limits your ability to perform daily activities or maintain social relationships. Interferes with sleep
☐8 - Intense, physical activity is severely limited. Conversing requires great effort	☐9 - Excruciating, Unable to converse. Crying out or moaning uncontrollably	☐10 - Unspeakable, Bedridden and possibly delirious	

Please check your pain level at its WORST

-

Pain level while Eating

-

Last time you had severe pain:

-

Cancellation Policy

Please read carefully before signing.

Dr. Spencer has continually strived to provide the highest standard of care to each patient and every patient by scheduling appointments on an individual basis. We do not double book our patients and do our best to allow adequate time to provide an in depth, thorough evaluation and treatment at each scheduled visit. In order to continue providing the highest quality of care to each patient, we kindly ask that you provide our office with 24 hours notice should you need to cancel or re-schedule. If you could please call during office hours, that would be greatly appreciated.

We understand that life throws us all surprises and that there may be occasional emergencies that will require a change in your schedule with short notice. We respectfully ask that you contact us as soon as possible. However, in the case of repeated missed appoinments, we do enforce a "no show," charge of $100. This fee will be payable before or at your next appointment.

Thank you for your cooperation and understaning. We at Orofacial Pain Associates look forward to providing you with excellent care and treatment for all of your orofacial pain and needs.

Damon W. Spencer DDS
3604 Preston Rd, Suite 500
Plano, TX 75093
972-758-2202
info@dallastmjpain.com

Patient Signature
-

Date
-

Patient Initials
-

Date
-

INSURANCE AND FINANCIAL POLICY

Insurance Financial Policy

Our office does not contract with any insurance company as a provider, regardless of your diagnosis, nor do we have any specific information regarding your insurance benefits. As a courtesy, we will assist you by providing an insurance form for you to file for your insurance reimbursement for any appropriate benefit.

We do not guarantee any payment from your insurance company.

We ask that our patients secure financial arrangements prior to their scheduled appointment. We offer options regarding financial arrangements for treatment. Payments may be made in full by cash, check, Visa, MasterCard, American Express or Discover.
If you have questions regarding your account, please contact our office at 972-758-2200

Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

By signing below, I hereby certify that I have read and understand the above statements.

Patient Last Name	Patient First Name	DOB
-	-	-
Patient/Guardian Signature	Date	
-	-	

Medication Policy

Respectfully, our office requires a 24-48 hour window to fill medications.

Most medications cannot be refilled over the weekends as they are not considered an emergency.

Medication refill requests made after 1pm will be submitted for refills the following business day.

For patients who are taking narcotic pain medication, you must be seen in the office for refills. Refills will not be given by phone or fax.

Thank you for your patience and cooperation,

Damon W. Spencer DDS
3604 Preston Rd., Suite 500
Plano, TX 75093
info@dallastmjpain.com

I have read and understand the above policy.

Patient Signature
-

Date
-

Patient Initials
-

Date
-

Opt-in Consent

Opt-in for messages

Please sign below to consent to receiving SMS text messages from Orofacial Pain Associates. Msg & data rates may apply. Reply STOP to opt out.

E-Signature (name or initials)

-

Release of Records

Damon W Spencer DDS
3604 Preston Rd.
Suite 500
Plano, TX 75093
Phone: (972) 758-2200
Fax: (972) 758-2202

Date
-

I, ____________
-

, herby authorize Dr. Spencer, who has examined and/or treated me (or my child), to release photo static copies, as well as have conversations with previous or referring doctors, pharmacies or insurance companies. This pertains to any and all information related to my (or my child's), physical conditions in the past, present or future. This includes any and all history, physical exams, pathological and x-ray reports, diagnosis, pharmacy records, prognosis and any other information pertaining to charges and/or statements for medical care.

I, ____________
-

, herby authorize any doctors who have examined or treated me (or my child), to release photo static copes of any and all information related to my physical condition in the past, present or in the future. This includes any and all history, physical exams, pathological and x-ray reports, diagnosis, pharmacy records, prognosis and any other information.

Damon W Spencer DDS
3604 Preston Rd., Ste. 500
Plano, TX 75093
info@dallastmjpain.com
Phone #: (972)758-2200
Fax #: (972)758-2202

I expressly understand and agree that no liability of any nature should by attached to Dr. Spencer, or my (or my child's) other treating doctors, in acting on this authorization and request.

Patient Signature(or Parent/Guardian if patient is under 18 years of age)
-

Date
-

Patient Initials
-

Date
-