Ottawa TMJ & Sleep Apnea Clinic

GENERAL DENTISTRY LIMITED TO TMJ & SLEEP APNEA MANAGEMENT

Welcome to the Ottawa TMJ & Sleep Apnea Clinic. Thank you for choosing us to diagnose and manage your condition. During your initial consultation, Dr. Dahan will spend one hour with you completing a comprehensive clinical examination and treatment plan.

To help us better treat you, please take a few minutes to fill out the following medical questionnaire and have it ready with you during your initial consultation.

Patient Name_____ Date Of Birth _____

Address_____

City _____ Province _____ Postal Code _____

Home Phone # _____ Mobile/Work Phone # _____

Marital Status _____ Occupation_____

Emergency Contact _____ Phone # _____ Relationship _____

1. Family Doctor _____ Phone # _____

Address _____ City_____ Province_____ Postal Code _____

2. Dentist_____ Phone # _____

Address _____ City_____ Province_____ Postal Code _____

3. Referring Doctor _____ Phone # _____

Address _____ City_____ Province_____ Postal Code _____

Patient Consent Form

Medical Information

Your information is private and confidential and will remain so in our clinic. Your medical information will not be shared with anyone unless you give us prior consent.

Consultation Report

As is standard practice in our medical profession, a consultation report will be forwarded to your referring doctor and dentist. Information that you provide in this document may be shared with them. If you do not want a report to be sent, please let us know during your initial visit.

Financial Policy

We are a fee-for-service practice. Therefore, we appreciate receiving full payment when services are rendered. All fees will be discussed with you before beginning any treatments.

Insurance

Our front desk will gladly help fill out all of your insurance forms in order for you to claim payments from your insurance company.

Consent to Photograph for Patient Care and Medical Record Purposes

Photographs may be taken during your first visit to assist in the diagnosis and treatment rendered.

Appointment Cancellation Policy

We strive to proved consistent quality patient care. Once an appointment is made, we ask that you keep it. If you cannot, we require 48 hours notice for cancellations.

Your signature below indicates that you have read and understood the above information

_____ _____

Name Date of Birth

_____ _____

Signature Date

Initial Patient Questionnaire

Patient Name: _____ Date of Birth: _____

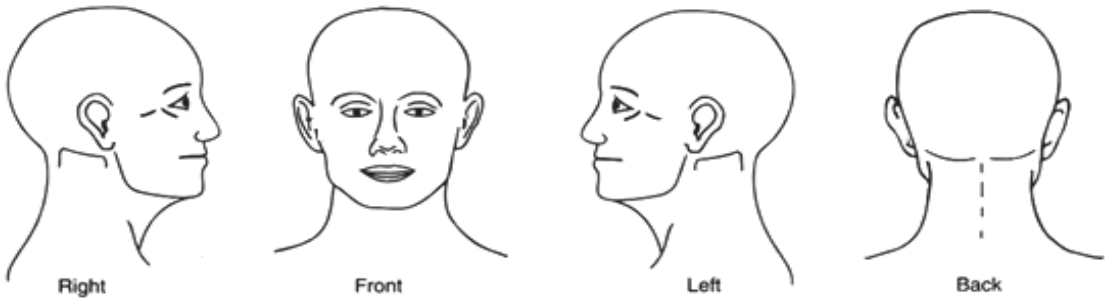
1. Please describe in writing the symptoms that you are experiencing today:

_____

_____

_____

2. On the diagram below, please shade the areas of your pain (if applicable):



3. Is the pain (check as many as apply):

Dull_____ Pressure_____ Ache_____ Sharp_____ Throbbing_____
Shooting _____ Burning _____ Stabbing _____ Electrical _____ Stabbing_____
Other (describe) _____

4. On the scale below, please rate your **AVERAGE** pain (0=no pain, 10=extreme pain)?

No Pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

5. When did you problem begin?

_____

_____

6. What seemed to have caused it?

_____

_____

Patient Name: _____ Date of Birth: _____

Have you had reactions to:	Yes	No	Notes	Are you allergic to:	Yes	No	Notes
Local anesthetics (Novocaine, etc.)				Penicillin, Amoxicillin, etc.?			
Codeine?				Other allergies? (Please list)			

Have you had or do you currently have	Yes	No	Have you had or do you currently have	Yes	No
Diabetes			Swollen ankles or joint disease		
Heart Murmur			Arthritis		
High Blood Pressure			Convulsions, epilepsy		
Chest Pain, Angina			Stroke		
Heart Attack(s)			Thyroid disease		
Bronchitis, chronic cough			Kidney		
Asthma			Stomach ulcer or colitis		
Tuberculosis			Immune system problems		
Emphysema			HIV or AIDS		
Difficulty breathing			Artificial joints		
Do you smoke/chew tobacco			Significant weight gain or loss		
Blood disorder (anemia)			Cancer/Malignancy		
Blood transfusion			Chemotherapy		
Bleeding tendency			Rheumatic Fever		
Jaundice or Hepatitis			Neurophathies		
Taken steroids			Psychiatric Disorder		

For women only	Yes	No
Are you pregnant or planning pregnancy?		
Are you taking birth control pills?		
Are you nursing?		

Patient Name: _____ Date of Birth: _____

Medication History

Please list all prescription, herbal, or over the counter medications that you are presently taking? Fully disclose in writing any non-prescription medications, including "street drugs". This information will be kept confidential and is needed to provide for you care.

Past Medical History

Please check any of the following conditions you have had or presently do have:

☐ Headaches ☐ Migraine ☐ Irritable Bowel ☐ Arthritis

☐ Depression ☐ Anxiety ☐ Fibromyalgia ☐ Back Pain

☐ Sleep Apnea ☐ Insomnia ☐ Eating Disorder ☐ PTSD

Personal History

Do you exercise regularly? ☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No

Do you have a history of prescription drug abuse? ☐ Yes ☐ No

Have you had problems with alcohol or drug use? ☐ Yes ☐ No