Patient Registration Form

Name_____ Sex_____ Marital Status_____

Address_____ Spouse's Name_____
(or policy holder, if patient is a minor)

City_____ State___ Zip_____ Spouse's Employer_____

Date of Birth_____ Age_____ Primary Insurance Carrier_____

Home Phone_____ Do You Have A Secondary Insurance?_____

Cell Phone_____ Name of Secondary Carrier_____

Work Phone_____ Is This Work Or Auto Accident Related?_____

Employer's Name_____ Claim#_____ Phone_____

Address_____ Doctor Referring You_____

City_____ State___ Zip_____ Friend/Relative Referring You_____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to:

The Therapy Institute, LLC.

The Therapy Institute bills according to your insurance guidelines. Your health insurance information will be kept on file in case of notice of dispute or rejection. You will be notified of any copays, deductibles or any limitations.

I understand I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is as valid as the original.

_____ _____
Signature Date

Patient Name: _____ Date: _____

Medical History

Please list all of your relevant surgeries:

_____

_____

_____

_____

_____

_____

_____

Please list any current medications you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NAME : _____ **DATE :** _____

Circle YES or NO…

Have you ever been told you have:

Cancer ? .... Yes……No
Diabetes ?..... ..... Yes……No
High blood pressure ? .... Yes……No
Heart disease ?..... ..... Yes……No
Angina/chest pain ? .... Yes……No
Stroke ? .... Yes……No
Osteoporosis ? .... Yes……No
Osteoarthritis ? .... Yes……No
Rheumatoid arthritis ?.... ..... Yes……No

In the past 3 months have you had or do you experience:

A change in your health ? .....Yes .... No
Nausea/Vomiting ? .....Yes .... No
Fever/chills/sweats ?.....Yes .... No
Unexplained weight change ? .....Yes .... No
Numbness or tingling ?.....Yes .... No
Changes in appetite ?.....Yes .... No
Difficulty swallowing ? .....Yes .... No
Changes in bowel or bladder function ?.....Yes .... No
Shortness of breath ?.....Yes ... No
Dizziness ? .....Yes .... No
Upper respiratory infection ? .....Yes .... No
Urinary tract infection ?.....Yes .... No

Circle YES or NO…

Do you have a history of:

Asthma ? ..... Yes.....No
Headaches ?..... Yes.....No
Bronchitis ? ..... Yes.....No
Kidney disease ?..... Yes.....No
Rheumatic fever ?..... Yes.....No
Ulcers ? ..... Yes.....No
Seizures ? ..... Yes.....No
Latex allergies ? ..... Yes.....No
Medication allergies ? ..... Yes.....No
List_____

Are you currently:

Pregnant ?..... Yes.....No
Depressed ? ..... Yes.....No
Under Stress ? ..... Yes.....No

Are you currently receiving any services to help manage stress and/or depression? YES NO

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐Moderate difficulty ☐Only with medication

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco? YES NO

If yes, _____Packs **X** _____Years.

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Are you currently involved in a lawsuit? YES NO

Date of last physical examination _____

List medications currently using: _____

_____

_____

List any past surgeries: _____

_____

_____

TMD DISABILITY INDEX QUESTIONNAIRE

Name: _____ **Date:** _____

Please read:
Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 – Communication (talking).
□ I can talk as much as I want without pain, fatigue or discomfort.
□ I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
□ I can't talk as much as I want because of pain, fatigue and/or discomfort
□ I can't talk much at all because of pain, fatigue and/or discomfort.
□ Pain prevents me from talking at all.

Section 2 - Normal living activities (brushing teeth/flossing).
□ I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
□ I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
□ I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
□ I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
□ I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 – Normal living activities (eating, chewing).
□ I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
□ I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
□ I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
□ I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
□ I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 – Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.).
□ I am enjoying a normal social life and/or recreational activities without restriction.
□ I participate in normal social life and/or recreational activities but pain/discomfort is increased.
□ The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instrument, singing).
□ I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
□ I have practically no social life because of pain.

Section 5 – Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).
□ I can yawn in a normal fashion, painlessly.
□ I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
□ I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
□ Yawning and opening my mouth wide are somewhat restricted by pain.
□ I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Section 6 – Sleep (restful, nocturnal sleep pattern).
 I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
 I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
 I fail to realize 6 hours restful sleep even with the use of pills.
 I fail to realize 4 hours restful sleep even with the use of pills.
 I fail to realize 2 hours restful sleep even with the use of pills.

Section 7 – Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatment, oral orthotics) eg, splints, mouthpieces), ice/health, etc.
 I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
 I can completely control my pain with some form of treatment.
 I get partial, but significant, relief through some form of treatment.
 I don't get "a lot of" relief from any form of treatment.
 There is no form of treatment that helps enough to make me want to continue.

Section 8 – Tinnitus, or ringing in the ear(s).
 I do not experience ringing in my ear(s).
 I experience ringing in my ears(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
 I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
 I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
 I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 9 – Dizziness (lightheaded, spinning and/or balance disturbance).
 I do not experience dizziness.
 I experience dizziness, but it does not interfere with my daily activities.
 I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
 I experience dizziness, which causes a marked impairment in the performance of my daily activities.
 I experience dizziness, which is incapacitating.

HIPAA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe relationship to patient:

_____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

(Optional)

My protected health information may be disclosed to:

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that, as set forth in The Therapy institute, LLC's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Therapy Institute, LLC
1660 Haslett Road, Suite 4
Haslett, MI 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority