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INTAKE FORM

Patient Information:

Name: ______________________________ Age: _______ Date: __________________

Address: (complete mailing address) ____

Phone No.: (____)______________ Date Of Birth: ___________ Soc. Sec. No.: ______________

Emergency contact:(____)__________________ Male___ Female___ Ht:____ Wt:____

Employer Information: ***(Your Employer At The Time You Were Injured)***

Name of Business: ____

Address: ____

Phone No.: (____)_________________________Fax No.: (____) ___________________________

Workers' Compensation Insurance Carrier Information:

Name: ____

Address: ____

Phone No.: (____)_________________________Fax No.: (____) ___________________________

Claims Representative: ____

Claim No.: ____

Attorney Information: ( ) Check If None

Name: ____

Address: ____

Phone No.: (____)_________________________Fax No.: (____) ___________________________

JOB DESCRIPTION

What Was Your Job Title **AT THE TIME OF YOUR INJURY**: ______________________________
Are you still working for the same employer? Yes☐ No☐
Describe the Nature Of Your Work: ____
Are you presently working? Yes☐ No☐
If yes, who are you presently working for? ___________________________________
What type of work are you **doing now**? ____________________________________

HISTORY OF THE INJURY

Date Of Injury: ________________ Time The Injury Occurred: _______________ A.M. ____ P.M.
Please Describe How Your Work Injury Occurred. **Be as detailed as possible:**

____
____
____

Please List the Injured Body Parts, **As A Result Of Your Work Injury:**

____
____
____

At the time of your initial injury was there direct trauma to your teeth, jaw, facial muscles? Yes☐ No☐ If yes, please explain which body part was injured and how it was injured.

____
____
____
____

Have you had any QME's or AME's completed since your industrial injury? Yes☐ No☐
Please place check marks next to area of specialty in which the QME/AME was completed in:
Internal Medicine Yes☐ No☐ **Psychiatry** Yes☐ No☐
Neurology Yes☐ No☐ **Orthopedics** Yes☐ No☐
Dental/ TMJ Yes☐ No☐ When was your dental QME/AME completed and by whom?____
____

If you have a copy of the AME/QME report, please bring it to your first dental appointment.

SOCIAL HISTORY:

☐ Employed ☐ Unemployed ☐ Retired
Tobacco:☐ Yes-Currently ☐ Yes-in the past ☐ No-never
How many packs/day? _________________________
Alcohol: ☐ Yes ☐ No How many drinks/weeks? __________________________
Illicit Drug Abuse:
☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Amphetamines ☐ Other: _________
Have you ever had a problem w/prescription medication (i.e.: misuse, abuse, addiction)?
☐ Yes ☐ No Which drugs? __________________________________

MEDICAL HISTORY

Please check if "yes or no" to indicate if you have ever had any of the following:

☐Y☐N AIDS/HIV
☐Y☐N Anemia
☐Y☐N Arthritis, Rheumatism
☐Y☐N Artificial heart valves
☐Y☐N Artificial joints
☐Y☐N Back problems
☐Y☐N Bleeding abnormally with extractions or surgery
☐Y☐N Blood disease
☐Y☐N Cancer
☐Y☐N Chemical dependency
☐Y☐N Chemotherapy
☐Y☐N Circulatory problems
☐Y☐N Congenital heart lesions

☐Y☐N Depression/Anxiety
☐Y☐N Diabetes –Type 1 or 2
☐Y☐N Emphysema
☐Y☐N Epilepsy
☐Y☐N Fainting or dizziness
☐Y☐N Glaucoma
☐Y☐N Heart murmur
☐Y☐N Heart problems
☐Y☐N Hepatitis type _____
☐Y☐N Herpes
☐Y☐N High blood pressure
☐Y☐N Jaundice
☐Y☐N Kidney disease
☐Y☐N Liver disease
☐Y☐N Mitral valve prolapse
☐Y☐N Nervous problems
☐Y☐N Cortisone treatments

☐Y☐N Radiation treatment
☐Y☐N Respiratory disease
☐Y☐N Shortness of breath
☐Y☐N Sinus trouble
☐Y☐N Stroke
☐Y☐N Swollen feet or ankles
☐Y☐N Tonsillitis
☐Y☐N Tuberculosis
☐Y☐N Tumor/growth on head or neck
☐Y☐N Ulcer
☐Y☐N Venereal Disease
☐Y☐N Weight loss, unexplained
☐ Other_______________
☐Y☐N Pacemaker
☐Y☐N Psychiatric care
☐Y☐N Cough persistent or bloody

Please list any Adult Hospitalizations/Surgeries: ____

____

____

Are you currently taking medication to relieve the effects of this injury? ☐Yes ☐No

Present Medications Taken: **IMPORTANT!!** CHECK BOX if prescribed for your work injury.

1. ____________________________________ ☐
2. ____________________________________ ☐
3. ____________________________________ ☐
4. ____________________________________ ☐
5. ____________________________________ ☐
6. ____________________________________ ☐
7. ____________________________________ ☐

Please list past medications (within the past 3 years) that you are no longer taking:

____

____

Allergies: ____

DENTAL HISTORY

Current Dentist's name: ______________________________ Last visit: ____________________

Dental history PRIOR to your work injury

Prior to your injury, did you have routine dental care? Yes☐ No☐

Who was your dentist? ____

What work was completed? ____

How frequently did you visit your dentist prior to your injury?

____

Dental history AFTER your work injury

Since your work injury have you had any dental care? Yes☐ No☐

Who was your dentist? ____

What work was completed? ____

Was the work completed on an industrial basis or private basis?

____

Have you had any teeth extracted after your industrial injury? ☐Yes ☐No

Have any of your teeth fractured since your industrial injury? ☐Yes ☐No

Have any of your teeth become more sensitive since your industrial injury? ☐Yes ☐No

Have any of your teeth shifted since your industrial injury? ☐Yes ☐No

Have any of your teeth become loose since your industrial injury? ☐Yes ☐No

Please Explain: ____

____

DENTAL CHIEF COMPLAINTS:

What are your current complaints?
(For example: Jaw pain, headache, dry mouth…etc.)

1. ____

2. ____

3. ____

Are you currently in pain? ☐Yes ☐No

Did any of the above symptoms exist before your industrial injury? (If yes, please explain)

____

____

____

Since your injury, has your condition? ___ Stayed the Same ___ Improved ___ Worsened
___Fluctuated, but overall has stayed about the same

If your condition has **worsened**? Please Explain: ____
____

Please check the box to indicate if you have any of the following symptoms:

☐ Difficulty opening wide
☐ Difficulty chewing
☐ Dry mouth
☐ Gums swollen or tender
☐ Jaw pain or tenderness
☐ TMJ- Temporomandibular Joint Pain
☐ Lock jaw
☐ Loose teeth or fillings
☐ Muscle Cramps
☐ Headaches
☐ Grinding or clenching of teeth
☐ Bleeding gums

Can you eat the foods you'd like to eat? Yes☐ No☐
Does the amount of saliva in your mouth seem too little? Yes☐ No☐
Does your mouth feel dry when eating a meal? Yes☐ No☐
Do you have difficulty swallowing any food? Yes☐ No☐
Do you sip liquids to aid in swallowing dry food? Yes☐ No☐
Do you wear a night guard? Yes☐ No☐ If Yes, Who made it?________________________
Do you require antibiotics before dental visits? Yes☐ No☐
Are you anxious about dental visits? Yes☐ No☐
How often do you brush? ___________________ How often do you floss? _______________

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The questions contained in these forms have been answered accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Moshe Benarroch, Dr. Ed De Andrade, or Dr. Eric Tsai to release my information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Moshe Benarroch, Dr. Ed De Andrade, or Dr. Eric Tsai insurance benefits otherwise payable to me.

X ____ Date: _____________________
Signature of patient or parent if minor

Notice of Privacy Practice Consent
(HIPAA)

Please Print Patient Name: ______________________________

Our notice of privacy practice consent provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, the patient consents to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a notice of privacy practices and that you have had the opportunity to review this notice.
- The Practice reserves the right to change the notice of privacy practices.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

My signature below indicates that I have read and understand this consent in its entirety, that my questions have been adequately answered, and that I have received a copy of the notice of privacy practices.

Name of Responsible Party: ______________________________
Please Print

Relationship to Patient: : ______________________________
Please Print (Self, Parent, Lawful Guardian)

____
Signature *Date*

____
Witness *Date*

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