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AME INTAKE FORM

Patient Information:

Name: _____ Age: _____ Date: _____

Address: (complete mailing address) _____

Phone No.: (____)_____ Date Of Birth _____

Soc. Sec. No.: _____ Male___ Female___ Ht:____ Wt:____

Emergency contact: Name: _____
Phone No.: (____)_____ Relationship: _____

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**: _____
When did you start working for this employer? _____
When did you stop working for this employer? _____
Are you still working for the same employer? Yes☐ No☐
When did you stop working for the same employer? _____
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**? _____
Please list your job duties/activities at work WHEN YOU WERE INJURED: _____
_____
_____

HISTORY OF THE INJURY

Date Of Injury: _____ Time The Injury Occurred: _____ A.M. ____ P.M.
Date you reported your injury to your Employer/Supervisor: _____
As a result of your injury, did your doctor place you on disability? Yes☐ No☐
If yes, how long were you on disability? _____
Are you still on disability? Yes☐ No☐
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.
_____
_____
_____
_____
Are you able to perform your NORMAL work duties? Yes☐ No☐
Please explain: _____
_____

HISTORY OF OTHER INJURIES

Have you ever experienced the same or similar symptoms/problems BEFORE this work injury? Yes☐ No☐ Please explain: _____

_____

Have you ever had a PRIOR work injury/injuries?
Yes☐ No☐ Please explain: _____

_____

Have you ever received a PRIOR Worker's Compensation Disability Award?
Yes☐ No☐ Please explain: _____

_____

Have you ever had any PRIOR, NON-WORK RELATED INJURIES? (example: sprains/strains, slips/falls, motor vehicle accidents, cumulative or repetitive traumas, etc.) Yes☐ No☐ Please explain: _____

_____

Have you ever had any NEW INJURIES involving body parts which are part of your current work injury? Yes☐ No☐ Please explain: _____

_____

HISTORY OF TREATMENT

When did you first seek treatment for your injury? Date: _____
Did your employer send you for treatment? Yes☐ No☐
Did you seek treatment on your own? Yes☐ No☐
Are you currently being treated for your injury? Yes☐ No☐

Please list all DENTISTS you have seen since your injury:
Name of Doctor: _____ City/Location: _____
Describe treatment and/or tests: _____
What did this doctor say was wrong with you? _____
Name of Doctor: _____ City/Location: _____
Describe treatment and/or tests: _____
What did this doctor say was wrong with you? _____

ACTIVITIES OF DAILY LIVING

Please indicate any limitations, difficulties, or impairments you have with any of the activities listed below:

1. Self-Care, Personal Hygiene: (Examples – urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating) _____

_____

_____

2. Sensory Function: (Examples – Touch, Sight, Hearing, Smell, Taste) _____

_____

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 with 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 become loose since your industrial injury? ☐Yes ☐No
Please Explain: _____

_____

DENTAL CHIEF COMPLAINTS:

Phone: 855-763-3926 Fax: 661-799-0168

What are your current Dental/TMJ 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)

Phone: 855-763-3926 Fax: 661-799-0168

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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