



Buffalo TMJ

Jeffrey M. Dolgos, DDS

Regarding: Consultation for TMJ Dysfunction and/or Obstructive Sleep Apnea
Treating Doctor: Jeffrey M. Dolgos, DDS
Office Manager: Kimberly Stachewicz

Your upcoming appointment is on: _____ at: _____

We look forward to working with you, and hope that we can help you find the solutions you seek. Below are some guidelines that we ask you to follow. This will help us keep the ambience in our office as peaceful as possible, while allowing us to see each patient in a timely fashion.

1. Please do not bring children under the age of 8 years to your appointment
2. Bring your insurance card
3. Bring any oral appliances you currently have (retainers, bite splints, partials, etc.)
4. Please be sure to complete all of the enclosed forms and bring them with you at the time of your visit, so that I can review this information before we talk.

- We have a waiting list of patients, and ask for at least **2 days advance notice for cancellations.**
- Our office is not open on Fridays, so if your appointment is on a Monday, please let us know by the previous Wednesday if you need to change your appointment, so that we can offer that time to another patient.
- Messages left on the machine after 12:00 noon on Thursday for Monday appointments will be considered missed appointments.
- The **fee for a missed appointment is \$75**, and you will not be permitted to make another appointment until this fee has been paid.
- If you are more than **15 minutes late**, you will not be seen.
- If you **miss 3 appointments**, you will be **dismissed** from the practice.

We have worked diligently over the years to refine and improve the solutions we are able to offer our patients. If you have any suggestions or feedback, good or bad, please share it with us. Successful treatment depends upon your active involvement in the process. You can rest assured that my staff and I are completely dedicated to helping you find your way back to good health and optimal function.

Thank you for choosing us to facilitate your return to good health and normal function. We all look forward to meeting you!

Sincerely,

Jeffrey M. Dolgos, DDS

TMJ Rehabilitation and Airway Management
Patient Information and History

Jeffrey M. Dolgos, D.D.S., F.A.G.D., F.A.A.C.P.

INSTRUCTIONS: Please answer all questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostic decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason behind each question. This information will remain confidential at all times.

We realize that it will take some time to complete this form. We can assure you that this information will be reviewed in detail before, during, and after your examination.

NAME: _____ M F S.S. # _____

IF CHILD, PARENTS NAME: _____ WHO IS RESPONSIBLE? _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____ CELL PHONE: (____) _____

E-MAIL: _____ SINGLE MARRIED DIVORCED SEPARATED WIDOW

AGE: _____ BIRTHDATE: _____ IF MARRIED, SPOUSE'S NAME: _____

OCCUPATION: _____ EMPLOYED BY: _____

SPOUSE'S OCCUPATION: _____ EMPLOYED BY: _____

NEAREST RELATIVE: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (____) _____

FAMILY DENTIST: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (____) _____

FAMILY PHYSICIAN: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (____) _____

PHARMACY: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (____) _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

HISTORY OF YOUR PRESENT CONDITION

1. Please try to describe your problem below. Keep your description brief enough to fit on the lines below.

Some questions to consider are: What is it that troubles you the most? When did the problem begin? Was there an event that you feel started the problem? Is there anything you have found that helps?

2. What do you hope I can do for you?

3. What would you consider to be a successful treatment outcome?

4. Do you have any specific concerns or fears you'd like to share with me?

5. Are you now, or are you planning to be involved in litigation relating to your problem? YES NO

If yes, please write the name and phone number of your attorney: _____

TMJ-RELATED SYMPTOM SURVEY

Use this chart to visualize your symptoms as you feel them.

You can use symbols such as arrows if you want, and feel free to write in any symptoms that aren't listed here. Get creative, and make this picture look like you feel.

RIGHT SIDE

- Ear pain
- Ear fullness
- Ringing
- Jaw pain
- Jaw clicking
- Jaw popping
- Jaw gets stuck
- Grinding noises

LEFT SIDE

- Ear pain
- Ear fullness
- Ringing
- Jaw pain
- Jaw clicking
- Jaw popping
- Jaw gets stuck
- Grinding noises

Headache

Eye pain

Sinus pain

- Tooth sensitivity
- Bite feels off
- Limited opening
- Difficulty talking
- Difficulty chewing

Throat pain or tightness

Difficulty swallowing

PHYSICAL PAIN AND DISCOMFORT SCALE

Below is a scale for rating your **physical** pain and discomfort experience.

Please **circle one number** in each category that **best** corresponds to the severity of your discomfort.

0=no pain or difficulty

10=worst imaginable pain or difficulty

Average Daily Pain/Discomfort (the amount of pain/discomfort you feel all the time)

0 1 2 3 4 5 6 7 8 9 10

Worst Pain (the most intense pain you've experienced related to your current problem)

0 1 2 3 4 5 6 7 8 9 10

Pain During Function (pain or discomfort you experience while eating, talking, singing, etc.)

0 1 2 3 4 5 6 7 8 9 10

EMOTIONAL DISTRESS AND ANXIETY SCALE

Below is a scale for rating your level of **emotional** distress.

Please **circle the number** below that **best** describes how you feel *most of the time*.

- 0 Generally peaceful and completely calm, feeling no distress whatsoever
- 1 Feeling OK, but could probably stand to be a little more relaxed
- 2 A little bit sad or off; mildly aware of some type of vague stress
- 3 A bit worried or upset, but in control
- 4 Noticeable discomfort or agitation, but tolerable
- 5 Very uncomfortable, can hardly stand it, but holding it together
- 6 Uncomfortable to the point it affects my life and my choices
- 7 Discomfort is severe, and emotional pain is interfering with my life
- 8 Intense discomfort which dominates my thoughts, and I struggle not to show it
- 9 Feeling desperate, helpless and unable to handle much more
- 10 Unbearably upset, overwhelmed, panicky, maybe on the verge of a breakdown

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician. Use the following scale to choose the most appropriate number for each situation:

Print out this test, fill in your answers and see where you stand.

0 = would *never* doze or sleep.

1 = *slight* chance of dozing or sleeping

2 = *moderate* chance of dozing or sleeping

3 = *high* chance of dozing or sleeping

Situation Chance of Dozing or Sleeping

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place _____

Being a passenger in a vehicle for an hour or more _____

Lying down in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch (no alcohol) _____

Stopped for a few minutes in traffic while driving _____

Total score (add the scores up) _____
(This is your Epworth score)

HEALTH HISTORY

- Y N Are you in good health?
 Y N Are you under a physician's care now?
 If so, please give reason(s) for treatment:

- Y N Have you smoked at least 100 cigarettes
 in your entire life?
 Y N Have you used tobacco in the last 30 days?
 Check all appropriate:
 ___ non-smoker
 ___ former smoker
 ___ current smoker _____ cigarettes per day
 ___ years as a smoker
- Y N Do you drink alcohol?
 ___ rarely
 ___ occasionally
 ___ regularly
- Y N Have you ever had a negative reaction to a local
 anesthetic like novocaine? ___YES ___NO
 If yes, please describe: _____

- Y N Are you allergic to any medications?
 If so, please list medication and reaction:

Please list any surgeries you have had in the past:
 (attach a separate sheet if needed)

Please list **any medications** you are taking here:
 (attach a separate sheet if needed)

Please check any conditions you have now or had in the past:

- | | | |
|---|--|--|
| <input type="checkbox"/> heart problems | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> lyme disease | <input type="checkbox"/> digestive problems |
| <input type="checkbox"/> stroke | <input type="checkbox"/> hepatitis | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> shingles | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> depression | <input type="checkbox"/> cold sores | <input type="checkbox"/> immune system dysfunction |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> cancer: type(s) _____ | | |
| other conditions: _____ | | |
| _____ | | |
| _____ | | |

DENTAL HISTORY

(Please check any that apply to you)

- | | | |
|---|---|---|
| <input type="checkbox"/> Had or have gum disease | <input type="checkbox"/> Bite adjusted by a dentist | <input type="checkbox"/> Root canal therapy |
| <input type="checkbox"/> Had gum surgery | <input type="checkbox"/> Chew gum regularly | <input type="checkbox"/> Partial denture |
| <input type="checkbox"/> Had wisdom teeth removed | <input type="checkbox"/> Had orthodontic treatment | <input type="checkbox"/> Complete denture |
| <input type="checkbox"/> Had other teeth removed | <input type="checkbox"/> Bite you fingernails | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Clench or Grind your teeth | <input type="checkbox"/> Teeth are worn down | <input type="checkbox"/> Gum recession |
| <input type="checkbox"/> Have loose teeth | <input type="checkbox"/> Have used a bite splint | <input type="checkbox"/> Fillings or crowns |

Do you have any other conditions not listed here? _____

SYSTEMIC SYMPTOM SURVEY

Please check if you are *currently* experiencing any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Recent unexplained weight changes | <input type="checkbox"/> Frequent heartburn |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Need glasses or contacts | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Frequent illness |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Bruising easily |
| <input type="checkbox"/> Ear fullness | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Difficulty stopping bleeding |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Joint pain (aside from jaw) |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Joint swelling (aside from jaw) |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Generalized muscle tightness or spasm |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Generalized muscle tenderness or pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent or recurring headaches |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Nerve pain |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Recent hair loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Difficulty sleeping |

Insurance Information

Western New York TMD
TMJ Dysfunction, Facial Pain, Sleep Apnea
Jeffrey M. Dolgos, DDS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) ____ / ____ / _____

Medical Insurance _____

Group Number _____ Policy Number _____

Subscriber Name _____ Date of Birth (MM/DD/YYYY) ____ / ____ / _____

Insurance Company's Address _____

City _____ State _____ Zip _____

No Fault Insurance _____

No Fault Insurance Company's Address _____

City _____ State _____ Zip _____

Claim Number _____

Date of the Accident (MM/DD/YYYY) ____ / ____ / _____

Worker's Compensation Insurance _____

Worker's Comp Insurance Company's Address _____

City _____ State _____ Zip _____

Claim Number _____

Date of the Injury (MM/DD/YYYY) ____ / ____ / _____