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

Parkland Professional Park
3075 Southwestern Blvd., Suite 204
Orchard Park, NY 14127

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Fax: 716-675-4872
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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: _____ BIRTHDATE: _____/_____/_____ ❑M ❑F

IF UNDER 18, NAME OF RESPONSIBLE PARTY: _____

YOUR STREET ADDRESS: _____

CITY/STATE/ZIP: _____

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

E-MAIL: _____

❑SINGLE ❑MARRIED ❑DIVORCED ❑SEPARATED ❑WIDOW / WIDOWER

YOUR OCCUPATION: _____ EMPLOYED BY: _____

SPOUSE'S OCCUPATION (if applicable): _____ EMPLOYED BY: _____

YOUR 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?

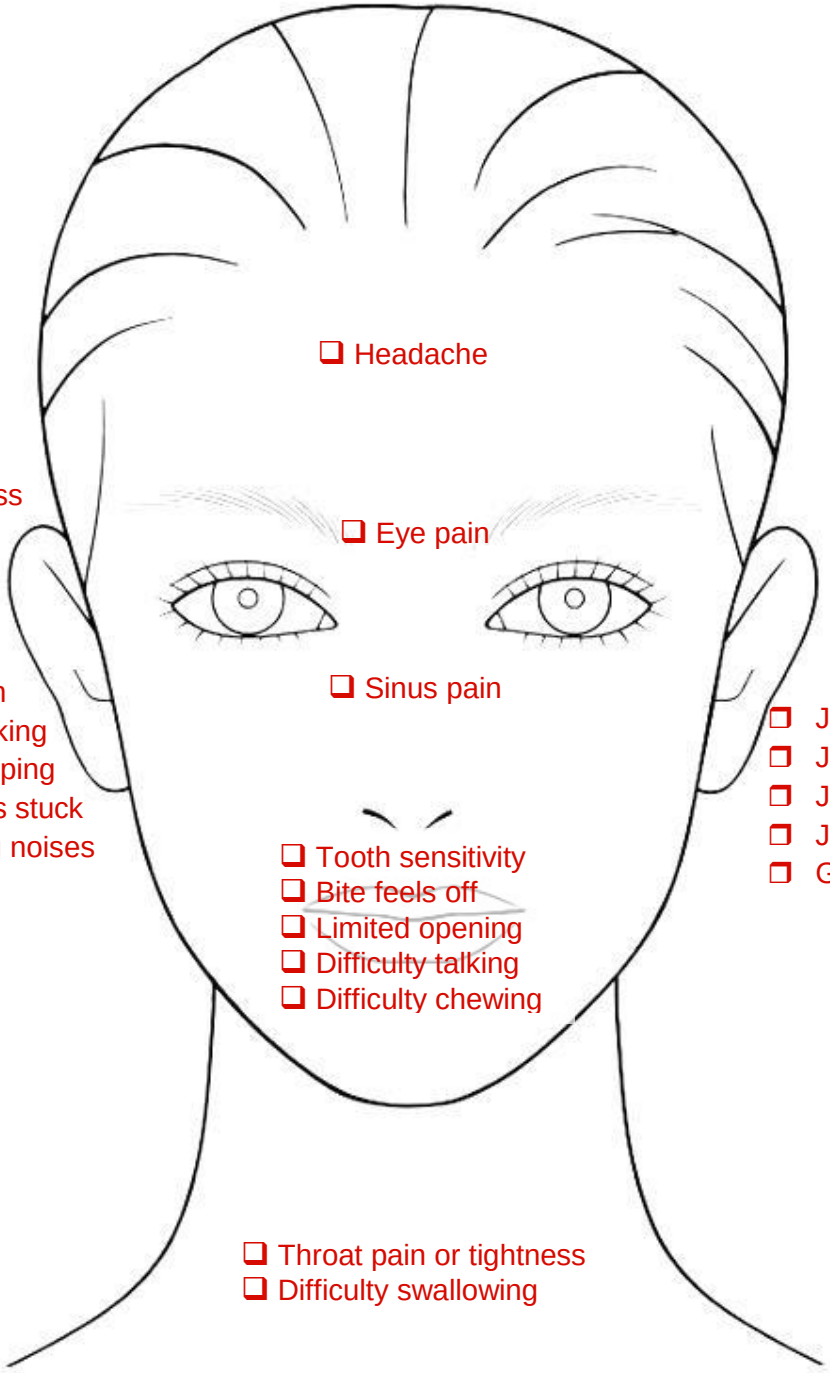
4. Do you have any specific concerns or fears you'd like to share with me?

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-RELATEDSYMPTOM 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.



❑ Headache

❒ Ear pain
❒ Ear fullness
❒ Ringing

❑ Eye pain

RIGHT SIDE

❒ Jaw pain
❒ Jaw clicking
❒ Jaw popping
❒ Jaw gets stuck
❒ Grinding noises

❑ Sinus pain

❒ Ear pain
❒ Ear fullness
❒ Ringing

LEFT SIDE

❒ Jaw pain
❒ Jaw clicking
❒ Jaw popping
❒ Jaw gets stuck
❒ Grinding noises

❑ 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)**

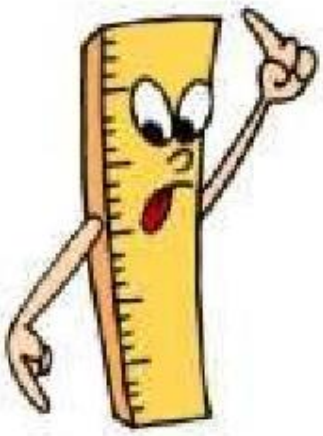
0 1 2 3 4 5 6 7 8 9 10

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

Please ***circle the number(s)*** below that *best* describes how you feel *most of the time*:



0 *The absence of any distress. Feeling calm and totally relaxed.*
1 Neutral feeling or just OK, not as relaxed as could be.
2 A mild irritation. First awareness of tension or vague stress.
3 Increased discomfort, unpleasant, but in control.
4 Noticeable discomfort or distress, perhaps agitation, but tolerable.
5 Discomfort is very uncomfortable, I can stand it.
6 Discomfort worsens and affects my life.
7 Discomfort is severe and emotional pain interferes with life.
8 Discomfort increases and it is in my thoughts constantly.
9 Discomfort is nearly intolerable.
10 *Discomfort is extreme and the worst imaginable. I feel panicky and overwhelmed.*

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:

___heart problems	___tuberculosis	___liver problems
___high blood pressure	___HIV	___kidney problems
___diabetes	___lyme disease	___digestive problems
___stroke	___hepatitis	___thyroid problems
___anxiety	___shingles	___arthritis
___depression	___cold sores	___immune system dysfunction
___sleep apnea	___mononucleosis	___bleeding problems

___**cancer**: *type(s)* _____

other conditions: _____
_____
_____

D E N T A L H I S T O R Y

(Please check any that apply to you)

___Had or have gum disease	___Bite adjusted by a dentist	___Root canal therapy
___Had gum surgery	___Chew gum regularly	___Partial denture
___Had wisdom teeth removed	___Had orthodontic treatment	___Complete denture
___Had other teeth removed	___Bite you fingernails	___Sensitive teeth
___Clench or Grind your teeth	___Teeth are worn down	___Gum recession
___Have loose teeth	___Have used a bite splint	___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:

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

Insurance Information

Buffalo TMJ

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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) ____ / ____ / _____