Oak Openings Dental
Matthew R. Lark D.D.S., M.A.G.D.
Temporomandibular Joint (TMJ)
And Occlusal Disorders
4315 N. Holland-Sylvania Road
Toledo, OH 43623
419-824-7900

Last Name_____First_____MI_____Date of Birth_____Age____

Sex: M or F Social Security #_____ Please Circle One: Single Married Separated Widow

Address_____ City_____ State _____ Zip Code _____

Email_____ Home Phone ( )_____ Cell Phone ( )_____

Driver's License # _____ Employer _____

Work Phone ( )_____ Occupation _____

Are you a full time student: Yes or NO If patient is a minor: Mother's DOB_____ Father's DOB_____

Name of Parent _____ Parent Social Security #_____

Parent Employer _____ Parent Phone ( )_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # ( )_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

___In-home Mailer __Social Media ___Insurance ___Practice Website ___Internet ___Family/Friend/Coworker

___Other *Who can we thank for you visit?*_____

Address if referred from a Professional Office _____

_____

HAVE YOU CONTACTED YOUR INSURANCE COMPANY AS TO WHETHER THERE IS COVERAGE IN YOUR CONTRACT FOR THIS TYPE OF PROBLEM? _____

Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance company. Insured patients are expected to take care of the fees as services are rendered unless other arrangements are made in advance. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. You are responsible for payment of your account within limits of our credit policy. If you have any questions we will, of course, assist you. Your eventual reimbursement will be determined by you insurance carrier.

I UNDERSTAND THAT I AM FINANCILLAY RESPONSIBLE FOR ALL COSTS OF DENTAL/MEDICAL TREATMENT.
SIGNATURE OF RESPONSIBLE PARTY _____Date_____

MEDICAL INSURANCE

Primary Medical Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Secondary Medical Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK #: _____ HM #: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK #: _____ HM #: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

WHEN DID YOUR PROBLEM FIRST OCCUR?

_____

_____

WHAT MAKES YOUR PAIN WORSE?

_____

_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

Practitioner Name: _____ Specialty: _____ Treatment: _____

Practitioner Name: _____ Specialty: _____ Treatment: _____

Practitioner Name: _____ Specialty: _____ Treatment: _____

WHAT OTHER INFORMATION IS IMPORTANT TO YOUR CONDITION?

_____

_____

_____

HAVE YOU EVER HAD X-RAYS TAKEN OF YOUR JAW JOINTS? _____

(If yes, please bring them to the office for your appointment)

TYPE OF X-RAYS TAKEN? _____

DATE TAKEN: _____

YES	NO	
_____	_____	Do you wear, or have you ever worn a splint, bite plate, or appliance?
_____	_____	Have you ever been treated for a bad bite?
_____	_____	Have you ever had orthodontic treatment?
_____	_____	Do you have extensive dental crowns and bridges?

YES	NO	
_____	_____	Do you have missing back teeth?
_____	_____	Do you wear a removable partial denture?
_____	_____	Have you ever been treated for problems of your jaw joints or facial muscle spasms?
_____	_____	Do you ever awaken with an awareness of your teeth or jaws?
_____	_____	Are you aware of clenching your teeth during the day?
_____	_____	Have you ever been told that you grind your teeth in your sleep?
_____	_____	Do your teeth hurt from biting?
_____	_____	Do you have any pain or soreness around your eyes, ears, or other parts of your body?
_____	_____	Do you have difficulty hearing?
_____	_____	Do you have tension headaches?
_____	_____	Do you have occasional headaches?
_____	_____	Do you have migraine headaches?
_____	_____	Do you frequently have stiff neck muscles or neckaches?
_____	_____	Do your jaw muscles become tired frequently?
_____	_____	Do you have difficulty opening your mouth widely?
_____	_____	Have you ever had arthritis?
_____	_____	Does any family member or relative have arthritis or gout?
_____	_____	Have you ever received a severe blow to the side of the head or jaw?
_____	_____	Have you ever had pain in your jaw joints?
_____	_____	Have you ever had problems with your ears, such as ringing or change of hearing?
_____	_____	Do you ever have grating sounds from your jaw joints?
_____	_____	Do you ever hear clicking or popping sounds from your jaw joints?
_____	_____	Do you feel your bite is closed?
_____	_____	Are you presently in pain from your jaw joints or muscles?
_____	_____	Does your pain or discomfort from your jaw joint interfere with your work or other activities?
_____	_____	Are there times when you notice that this problem or pain is less or gone completely?
_____	_____	Are you afraid your problem is serious?
_____	_____	Do you feel you need treatment for this problem?
_____	_____	Do you have problem with insomnia?
_____	_____	Are you under a great deal of stress, job, family, social, school.....?
_____	_____	Do you take more than one alcoholic drink per day?
_____	_____	Do you smoke cigarettes, cigars or a pipe?
_____	_____	Do you bite your nails, tongue or lips?
_____	_____	Do you have young children in your care?

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency_____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea)_____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements_____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment . Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) *Date*

Patient Name (print) _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Patient Name (Printed)

_____

Signature

_____

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other *(Please Specify)*

_____

_____

_____