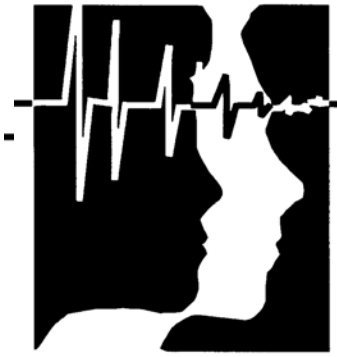


HEAD AND NECK

DIAGNOSTIC CENTER

205 W. RANDOLPH
SUITE 1800
CHICAGO IL 60606

Thank you for selecting the Head And Neck Diagnostic Center for evaluation of your problem. We look forward to meeting you. To help us best serve you and make your visits most time-efficient for you, we ask that prior to your first visit, you complete all the forms in this booklet to the best of your ability and as completely as possible.

It is vital that you bring this completed booklet with you on your first visit. You will notice that there is a page on which to describe the history of your problem. If you would prefer (we would) instead of filling it in by hand, you can provide separate typed pages.

Additionally, please bring any prior radiologist reports, x-rays, MRI, or CAT scans you may have, or can get, which were taken with respect to this problem. If you wear or have worn a TMJ appliance or night guard, and you still have it or them, please bring it or them.

Once again, we look forward to meeting you and helping you with your problem. If you have any questions please feel free to call the Center.

PATIENT INFORMATION

TITLE: Mr. Mrs. Ms. Dr.

STREET ADDRESS: _____ SUITE/APT# _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ / _____ - _____ SOCIAL SECURITY NUMBER _____-_____-____

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: _____ MARITAL STATUS: _____

EMPLOYED BY:_____ PHONE: _____ / _____ - _____

ADDRESS:_____CITY: _____ STATE: ____ ZIP: _____

IF UNDER 18:

PARENT/GUARANTOR: _____ RELATION: _____

ADDRESS: _____ PHONE: _____ / _____ - _____

****MEDICAL INSURANCE****

COMPANY:_____ PHONE: ____ / _____ - _____

ADDRESS:_____ CITY: _____STATE: _____ZIP: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH_____

RELATION TO INSURED: __SELF __SPOUSE __CHILD __OTHER_____

INSURED'S EMPLOYER_____

EMP'S ADDRESS: _____ CITY: _____ STATE: ____ ZIP:___

PLAN/GROUP # _____ INSURED'S I.D. # _____

WHO REFERRED YOU TO THE HEAD AND NECK DIAGNOSTIC CENTER?

NAME:

INSURANCE INFORMATION

Benefits for treatment for Temporomandibular Joint Dysfunction (TMJ) are customarily filed under a major medical insurance policy, not a dental plan.

Most major medical insurance may provide coverage for a portion of your TMJ therapy. A major medical insurance policy is actually a legal contractual agreement made between you or your employer and an insurance carrier. It establishes the responsibility of the insurance carrier to provide benefit payments to you or your dependents for any treatment that is considered to be an insured liability under the terms of that contract. If your policy provides coverage for "articular" or "joint disorders", and does not specifically exclude Temporomandibular Joint Dysfunctions and Diseases, your policy should provide a reimbursement (usually 80% of reasonable and customary charges) of the fees paid by you for TMJ therapy.

We suggest that you review your medical insurance policy or "Benefits Booklet" so that you may be made aware of the specific limitations of your major medical contract. If your present policy does not contain the coverage that you think it contains, we suggest you change policies or purchase a rider for your present policy to get the coverage you desire.

This office does not deal directly with insurance carriers regarding benefits. We do not accept assignment of benefits nor can we commence treatment contingent upon payment by an insurance carrier. We deal directly with each patient individually and expect you to pay us for services as they are rendered on a visit by visit basis. This means that at the end of your appointment you must physically write out a check or sign a charge card slip.

This office will assist you by providing you with completed medical insurance forms listing the service/s actually performed. These forms will be generated by our computer system. We will also aid you by providing explanations of procedures to your insurance carrier if requested. We will not originate any telephone calls to your insurance carrier from this office. However, we will answer telephone requests from your insurance carrier on a reasonable basis. It is your responsibility to pursue reimbursement from your insurance carrier for monies you have paid to us for your treatment.

There are over 2300 insurance carriers, each having from one to several major medical policies in existence, and each one containing clauses that make it different from all the others. **We advise you to read your policy carefully and to call your insurance carrier if you have any questions concerning your coverage for services rendered.**

Thank you for your cooperation.

Signature _____, Date _____

RELEASE OF DOCUMENTS

I hereby authorize release of any medical information to any insurance carrier or attorney concerning my treatment and physical condition in order to process any claim for reimbursement of charges incurred at this office by me.

I hereby authorize release of any medical/dental information to any of my health care practitioners of record.

I hereby authorize the release of and receipt of any medical information from any of my doctors of record to A. Richard Goldman, D.D.S.

Name_____ DATE _____

Dr. Goldman and/or the Head and Neck Diagnostic Center performs no diagnostic, preventative dentistry nor dental treatment except that Necessary for Craniomandibular Disorders.

Although Dr. A. Richard Goldman and the Head and Neck Diagnostic Center is licensed as a general dentist in the state of Illinois, I specifically am seeking him or it out for problems related to **craniomandibular disorders only**, and I do not and will not, in any way, consider him, it, or any dentist employed by him or it as my personal dentist. I will not hold Dr. Goldman or the Head and Neck Diagnostic Center or any dentist employed by him or it responsible for the diagnosis and/or treatment of any dental diseases or processes other than those related to craniomandibular disorders. These other diseases or processes include, but are not limited to, tooth decay, missing teeth, abscesses, periodontal diseases, tumors, endodontic or periapical diseases, tooth position or skeletal anomalies, and emergency treatment not related to craniomandibular disorders.

I further declare that I am currently under the care of, and will remain under the care of a licensed dentist other than Dr. Goldman or the Head and Neck Diagnostic Center or any dentist employed by him or it for **all** of my dental needs other than craniomandibular disorders.

If I undergo treatment for craniomandibular disorders with Dr. Goldman, the Head and Neck Diagnostic Center or any dentist employed by him or it, I agree to have dental prophylaxis and dental examinations done **by my dentist** at least three times per year or more frequently if deemed necessary by my dentist. I agree to be solely responsible for keeping track of, and scheduling the appointments referred to in this paragraph.

Name _____ Date _____

DEAR PATIENT: Please list below ***ALL*** health care practitioners *(including ENT, neurologist, orthopedist, psychiatrist, etc.)*, dentists, chiropractors, osteopaths, physical therapists, or other health care providers that you have consulted.
PLEASE PLACE AN "**X**" TO THE LEFT OF YOUR REFERRING HEALTH CARE PRACTITIONER.

PATIENT'S NAME :

***PERSONAL DENTIST*:**____**Specialty:**______________________
Address:____
City/State/Zip:____ **Phone:**_____________________
Diagnosis & Treatment:____
____

***PERSONAL PHYSICIAN*:**____**Specialty:**______________________
Address:____
City/State/Zip:____ **Phone:**_____________________
Diagnosis & Treatment:____
____

OTHER HEALTH CARE PRACTITIONERS

***NAME*:**____**Specialty:**______________________
Address:____
City/State/Zip:____ **Phone:**_____________________
Diagnosis & Treatment:____
____
***NAME*:**____**Specialty:**______________________
Address:____
City/State/Zip:____ **Phone:**_____________________
Diagnosis & Treatment:____
____
***NAME*:**____**Specialty:**______________________
Address:____
City/State/Zip:____ **Phone:**_____________________
Diagnosis & Treatment:____
____

PATIENT'S NAME : ____

OTHER HEALTH CARE PRACTITIONERS *(continued)*

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

***NAME*:**____**Specialty:**____________________
Address:____
City/State/Zip:____ **Phone:**____________________
Diagnosis & Treatment:____

PLEASE REQUEST ADDITIONAL FORMS IF NEEDED (312.920.0505)

PATIENT: _____ **DATE:** _____

PLEASE HELP US UNDERSTAND YOUR PROBLEM AS COMPLETELY AS POSSIBLE

ON THIS OR SEPARATE SHEETS, STARTING FROM THE ONSET OF YOUR FIRST SYMPTOM PLEASE DESCRIBE, IN CHRONOLOGICAL ORDER, THE FOLLOWING: (GIVE DATES, IF POSSIBLE -MONTHS OR YEARS IF NECESSARY)

1. Initial symptoms
2. What precipitated these symptoms
3. Progression of symptoms
4. Healthcare professionals with whom you have consulted (names only)
5. Treatment given by these healthcare professionals and the results of these treatments
6. What makes your symptoms worse or better at this time
7. Any trauma that you have experienced to your head and neck-- ever (to the best of your Knowledge)
8. Any automobile accidents in which you have been involved
9. Other information which you feel will help our understanding of your problem

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY ARE YOU SEEKING TREATMENT?

PLEASE ORDER YOUR COMPLAINTS BY NUMBER WITH #1 BEING MOST IMPORTANT.

_____BACK PAIN	_____JAW CLICKING	_____PAIN WHILE CHEWING
_____DIZZINESS	_____JAW JOINT NOISES	_____RINGING IN EARS
_____EAR PAIN	_____JAW LOCKING	_____SHOULDER PAIN
_____EAR/SINUS CONGESTION	_____JAW PAIN	_____THROAT PAIN
_____FACIAL PAIN	_____LIMITED MOUTH OPENING	_____TINNITIS
_____FATIQUE	_____MUSCLE TWITCHING	_____VISUAL DISTURBANCE
_____HEADACHES	_____NECK PAIN	
_____CAN'T OPEN MOUTH	_____PAIN BEHIND EYES	

_____OTHER:_____

_____OTHER:_____

_____OTHER:_____

CHECK ANY MEDICATIONS / SUBSTANCES TO WHICH YOU ARE ALLERGIC:

[ ] ANTIBIOTICS	[ ] METALS
[ ] ASPIRIN	[ ] PENICILLIN
[ ] BARBITUATES	[ ] PLASTICS
[ ] CODEINE	[ ] SEDATIVES
[ ] IODINE	[ ] SLEEPING PILLS
[ ] LATEX	[ ] SULFA DRUGS
[ ] LOCAL ANESTHESIA	

[ ] OTHER ALLERGENS:_____

_____

SIGNATURE_____**DATE**_____

CHECK ANY MEDICATIONS YOU ARE CURRENTLY TAKING --GIVE NAME AND DOSAGE:

XOXO

[ ] ANTIBIOTICS _____

[ ] ANTICOAGULANTS _____

[ ] BARBITUATES _____

[ ] BLOOD THINNERS _____

[ ] CODEINE _____

[ ] CORTISONE _____

[ ] DIET PILLS _____

[ ] HEART MEDS _____

[ ] INSULIN _____

[ ] MUSCLE RELAXER _____

[ ] ANTI ANXIETY _____

[ ] PAIN MEDICATION _____

[ ] SLEEPING PILLS _____

[ ] SULFA DRUGS _____

[ ] TRANQUILIZERS _____

OTHER MEDICATIONS:

[ ] 1. _____

[ ] 2. _____

[ ] 3. _____

[ ] 4. _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CHECK WHERE APPROPRIATE

[ ] ADENOIDS /TONSILS REMOVED

[ ] ANEMIA

[ ] ARTERIOSCLEROSIS

[ ] ASTHMA

[ ] AUTOIMMUNE DISORDERS

[ ] BLEEDING EASILY

[ ] BLOOD PRESSURE HIGH LOW

[ ] BRUISING EASILY

[ ] CANCER

[ ] CHEMOTHEROPY

[ ] CHRONIC FATIQUE

[ ] COLD HANDS & FEET

[ ] CURRENT PREGNANCY

[ ] DEPRESSION

[ ] DIABETES

[ ] DIFFICULTY CONCENTRATING

[ ] DIZZINESS

[ ] EMPHYSEMA

[ ] EPILEPSY

[ ] EXCESSIVE THIRST

[ ] FLUID RETENTION

[ ] FREQUENT COUGH

[ ] FREQUENT ILLNESS

[ ] FREQUENT STRESS

[ ] GENERAL ANESTHESIA

[ ] GLAUCOMA

[ ] GOUT

[ ] HAY FEVER

[ ] HEARING IMPAIRMENT

[ ] HEART MURMUR

[ ] HEART DISORDER

[ ] HEART PACEMAKER

[ ] HEART PALPITATIONS

[ ] VALVE REPLACEMENT

[ ] HEMOPHILIA

[ ] HEPATITIS

[ ] HYPOGLYCEMIA

MEDICAL HISTORY
CONTINUED-PLEASE CHECK

[ ] IMMUNE SYSTEM DISORDER

[ ] INJURY TO:

___FACE ___MOUTH

___NECK ___TEETH

[ ] INSOMNIA

[ ] INTESTINAL DISORDER

[ ] JAW JOINT SURGERY

[ ] KIDNEY PROBLEMS

[ ] LIVER DISEASE

[ ] MENIERE'S DISEASE

[ ] MENSTRAL CRAMPS

[ ] MULTIPLE SCLEROSIS

[ ] MUSCLE ACHES

[ ] MUSCLE SHAKING (TREMORS)

[ ] MUSCLE SPASMS OR CRAMPS

[ ] MUSCULAR DYSTROPHY

[ ] NEED EXTRA PILLOWS
(TO HELP BREATHING AT NIGHT)

[ ] NERVOUS SYSTEM IRRITABILITY

[ ] NERVOUSNESS

[ ] NEURALGIA

[ ] OSTEOARTHRITIS

[ ] OSTEOPOROSIS

[ ] OVARIAN CYSTS

[ ] PARKINSON'S DISEASE

[ ] POOR CIRCULATION

[ ] PRIOR ORTHODONTICS

[ ] PSYCHIATRIC CARE

[ ] RADIATION TREATMENT

[ ] RHEUMATIC FEVER

[ ] RHEUMATOID ARTHRITIS

[ ] SCARLET FEVER

[ ] SHORTNESS OF BREATH

[ ] SINUS PROBLEMS

[ ] SKIN DISORDER

[ ] SLOW HEALING SORES

[ ] SPEECH DIFFICULTIES

[ ] STD

[ ] STROKE

[ ] SWOLLEN-STIFF-PAINFUL JOINTS

[ ] FREQUENT COLDS

[ ] EAR INFECTIONS / SORE THROATS

[ ] TIRED MUSCLES

[ ] TUBERCULOSIS

[ ] TUMORS

[ ] URINARY DISORDERS

[ ] WISDOM TEETH REMOVAL

[ ] OTHER MEDICAL/DENTAL HISTORY **INCLUDE ALL SURGERIES, WITH APPROXIMATE DATES AND TYPE OF ANESTHESIA USED**

_____

_____

_____

_____

_____

SIGNATURE_____ **DATE**_____

SYMPTOM KEY

LOCATION:	**" *L* "=LEFT**	**" *R* "=RIGHT**	**" *B* "=BOTH SIDES**		
SEVARITY:	**" *MI* "=MILD**	**" *MO* "=MODERATE**	**" *S* "=SEVERE**		
FREQUENCY:	**" *O* "=OCCASIONAL**	**" *F* "=FREQUENT**	**" *C* "=CONSTANT**		
DURATION:	**" *S* "=SECONDS**	**" *M* "=MINUTES**	**" *H* "=HOURS**	**" *D* "=DAYS**	**" *W* "=WEEKS**

HEAD PAIN USING KEY FOR REFERENCE, PLEASE CIRCLE AS APPROPRIATE

LOCATION	SEVERITY	FREQUENCY	DURATION
L R B FRONT OF YOUR HEAD	*MI MO S*	*O F C*	*S M H D W*
L R B ENTIRE HEAD	*MI MO S*	*O F C*	*S M H D W*
L R B TOP OF YOUR HEAD	*MI MO S*	*O F C*	*S M H D W*
L R B BACK OF YOUR HEAD	*MI MO S*	*O F C*	*S M H D W*
L R B IN YOUR TEMPLES	*MI MO S*	*O F C*	*S M H D W*
L R B _____	*MI MO S*	*O F C*	*S M H D W*
L R B _____	*MI MO S*	*O F C*	*S M H D W*
L R B _____	*MI MO S*	*O F C*	*S M H D W*

JAW PAIN

PLEASE CIRCLE

shaded areas for Center use only

L R B JAW PAIN ON OPENING

L R B JAW PAIN WHILE CHEWING

L R B JAW PAIN AT REST

EYE RELATED CONDITIONS

PLEASE CHECK

[ ] BLURRED VISION

[ ] DOUBLE VISION

[ ] EYE PAIN

[ ] PAIN OR PRESSURE BEHIND EYES

[ ] LIGHT SENSITIVITY

JAW SYMPTOMS
PLEASE CHECK

shaded areas for center use only

[ ] JAW CLICKS

[ ] JAW LOCKS CLOSED

[ ] JAW LOCKS OPEN

[ ] JAW POPPING

[ ] TEETH CLENCHING

[ ] TEETH GRINDING

EAR CONDITIONS CONT.
PLEASE CHECK

[ ] PAIN IN FRONT OF THE EAR

[ ] RECURRENT EAR INFECTIONS

[ ]TINNITUS (ear ringing)

THROAT NECK AND BACK PLEASE CHECK

[ ] TIGHTNESS IN THROAT

[ ] LOWER BACK PAIN

[ ] MIDDLEBACK PAIN

[ ] BACK PAIN-UPPER

[ ] CHRONIC SORE THROAT

[ ] FEEL FOREIGN OBJECT IN THROAT

[ ] DIFFICULTY IN SWALLOWING

[ ] LIMITED MOVEMENTIN NECK

[ ] NECK PAIN

[ ] NUMB HANDS OR FINGERS

[ ] SCIATICA

[ ] SCOLIOSIS

[ ] SHOULDER PAIN

[ ] SHOULDER STIFFNESS

[ ] OTHER_____

EAR RELATED CONDITIONS PLEASE CHECK

[ ] BUZZING IN THE EARS

[ ] EAR CONGESTION

[ ] EAR PAIN

[ ] HEARING LOSS

[ ] PAIN BEHIND THE EAR

THROAT NECK & BACK CONT.
PLEASE CHECK

[ ] SWELLING IN THE NECK

[ ] SWOLLEN GLANDS

[ ] THYROID ENLARGEMENT

[ ] TINGLING HANDS OR FINGERS

[ ] WRYNECK

MOUTH & NOSE PLEASE CHECK

[ ] BROKEN TEETH

[ ] BURNING TONGUE

[ ] CHRONIC SINUSITIS

[ ] DRY MOUTH

[ ] FREQUENT BITING OF THE CHEEK

[ ] FREQUENT SNORING

LIFESTYLE RELATED CONDITIONS

[ ] UNDER UNUSUAL STRESS

[ ] RECENT CHANGE IN LIFESTYLE

[ ] RECENT CHANGE IN WORK

[ ] DRINK 4 OR MORE CUPS OF COFFEE DAILY?

[ ] SMOKE OR USE TOBACCO?

[ ] TAKE MORE THAN ONE ALCOHOLIC DRINK DAILY? [ ] IF YES, HOW MUCH_____

[ ] DOES ANY FAMILY MEMBER HAVE THE SAME OR SIMILAR PROBLEM?

IF YES, PLEASE EXPLAIN_____

_____

WHAT MAKES YOUR PAIN/DISCOMFORT WORSE?_____

_____

WHAT MAKES YOUR PAIN/DISCOMFORT BETTER?_____

_____

[ ] HAVE YOU BEEN IN THE HOSPITAL FOR ANY REAON IN THE LAST 5 YEARS? IF YES PLEASE EXPLAIN

_____

_____

_____

_____

_____

ADDITIONAL HEALTH HISTORY COMMENTS:

_____

_____

_____

_____

_____

SIGNATURE_____ **DATE**_____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN ||||

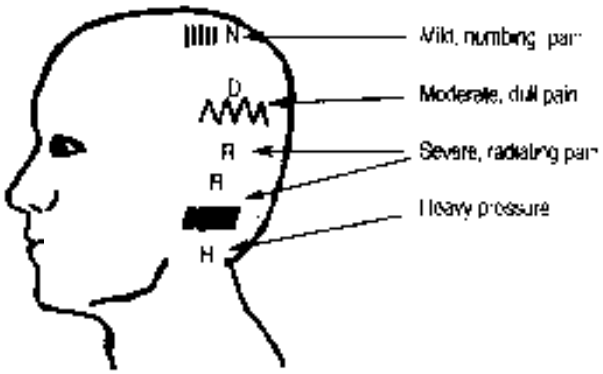
MODERATE PAIN ∧∧∧

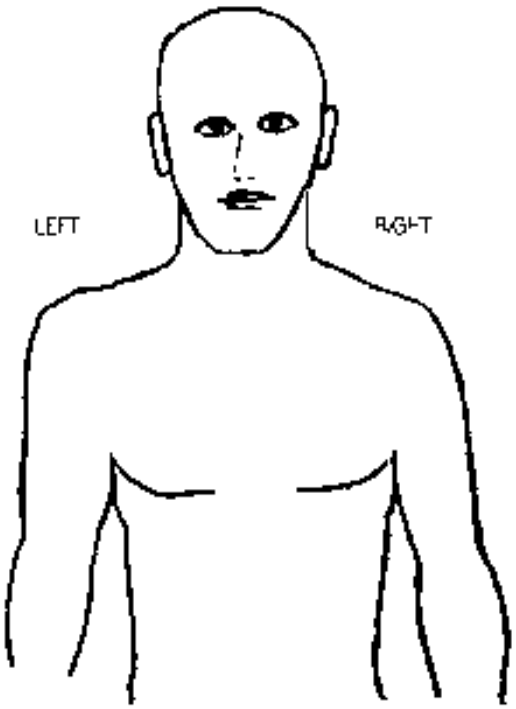
SEVERE PAIN ▬

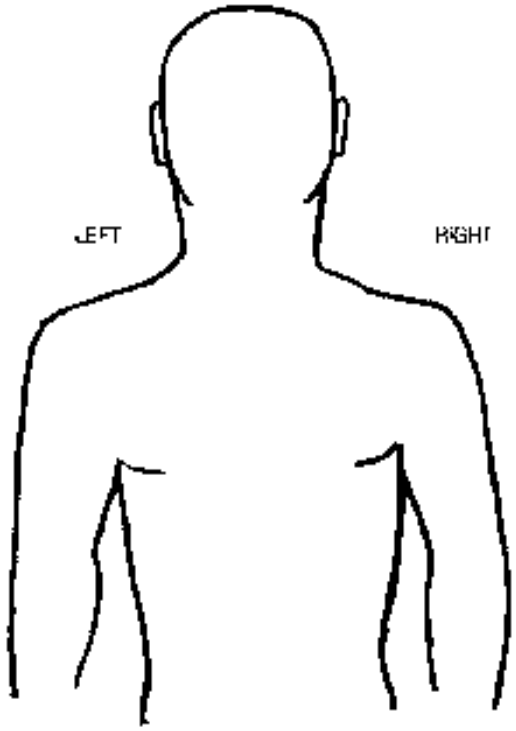
B Burning
D Dull
H Heavy Pressure
N Numbing
S Sharp
T Tingling
R Radiating

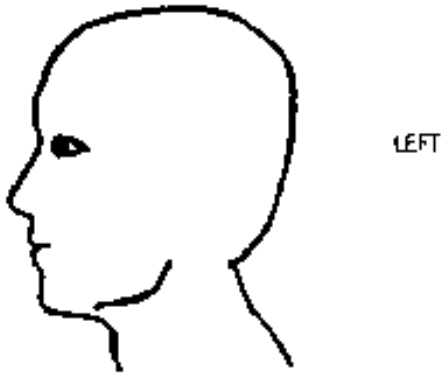
EXAMPLE:

INDICATES:









IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, THAT YOU FEEL IS RESPONSIBLE FOR YOUR PROBLEM, COMPLETE THIS SECTION. IF NOT, YOU ARE FINISHED

HISTORY OF ACCIDENT OR INCIDENT

DATE OF ACCIDENT OR INCIDENT: _____

WERE YOU? PLEASE CHECK WHERE APPROPRIATE

[ ] A PASSENGER IN A VEHICLE
[ ] THE DRIVER OF A VEHICLE
[ ] A PEDESTRIAN
[ ] AT WORK
[ ] DID YOU FALL?
[ ] WERE YOU HIT BY AN OBJECT
[ ] DID YOU HIT AN OBJECT?
[ ] OTHER:_____

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT? **If not, skip to next page**

PLEASE CHECK

[ ] AT FRONT END
[ ] AT REAR END
[ ] AT FRONT RIGHT AREA
[ ] AT FRONT LEFT AREA
[ ] AT REAR RIGHT AREA
[ ] AT LEFT REAR AREA
[ ] HEAD ON
[ ] ON DRIVER'S SIDE
[ ] ON PASSENGER'S SIDE
[ ] OTHER_____

INDICATE IF THERE WAS ANY DIRECT TRAUMA. AUTO OR NON-AUTO

DID YOUR PLEASE CHECK

[ ] FOREHEAD
[ ] FACE
[ ] CHIN
[ ] SIDE OF HEAD
[ ] BACK OF HEAD
[ ] TOP OF HEAD
[ ] TEETH
[ ] JAW
[ ] OTHER:_____

<<FORCIBLY STRIKE>>

[ ] STEERING WHEEL
[ ] WINDSHIELD
[ ] PASSENGER'S SIDE WINDOW
[ ] DRIVER'S SIDE WINDOW
[ ] PASSENGER'S SIDE DOOR
[ ] DRIVER'S SIDE DOOR
[ ] HEAD REST
[ ] SEAT
[ ] ROOF
[ ] INTERIOR OF CAR
[ ] OTHER:_____

_____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT?
PLEASE CHECK ALL APPROPRIATE

[ ] HEAD
[ ] NECK
[ ] FACE
[ ] JAW
[ ] LEFT SHOULDER
[ ] RIGHT SHOULDER
[ ] LEFT ARM
[ ] RIGHT ARM
[ ] LOWER BACK
[ ] UPPER BACK
[ ] OTHER:_____

WHEN DID SYMPTOMS START_____

BRIEFLY DESCRIBE THE HISTORY OF THE SYMPTOMS, ACCIDENT OR INCIDENT:_____

_____

_____

_____

CHECK IF YES:

[ ] DID YOU GO TO THE HOSPITAL? IF YES [ ] BY CAR? [ ] BY AMBULANCE?

[ ] WERE YOUTAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION _____

_____DATE YOU WERE RELEASED FROM THE HOSPITAL

WHICH HOSPITAL?_____

WHAT TREATMENT,IF ANY, DID YOU RECEIVE AT THE HOSPITAL _____

_____

[ ] HAS A PHYSICIAN OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

IF YES, PLEASE EXPLAIN_____

_____

IF YOU HAVE HAD A PREVIOUS ACCIDENT, PLEASE GIVE A DESCRIPTION:_____

_____

_____DATE:_____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE YOU WERE TREATED FOR THIS

PREVIOUS ACCIDENT_____

_____

_____

_____

IF YOU HAVE MISSED ANY WORK BECAUSE OF THIS ACCIDENT PLEASE GIVE DATES:_____

_____

_____

SIGNATURE_____**DATE**_____