Maribel M. Vann, DDS
PREVENTION · PROTECTION · RENEWAL

8500 Executive Park Ave, Suite 408, Fairfax, VA 22031
Telephone: (703) 204-1555 Fax: (703) 204-1610

Medical History and TMJ Questionnaire

This questionnaire was designed to provide important facts regarding your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

Today's Date: Prefix: ◯ Ms ◯ Miss ◯ Mrs ◯ Mr

Full Name:

Birth Date: Age:

Occupation: Employer:

Home Address: City: State: Zip:

Home Phone: Work Phone: Cell:

Email Address:

Name of Physician: Phone:

Physician's Address:

Name of Dentist: Phone:

Dentist's Address:

Referral's Name: Phone:

Referral's Address:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Patient's Signature: Date:

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ALLERGIES TO MEDICATIONS, SUBSTANCES, AND MATERIALS

Name the Drug	Reaction You Had

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans per day?

Alcohol Do you drink alcohol? ◯ Yes ◯ No

How many drinks per week?

Tobacco Do you use tobacco? ◯ Yes ◯ No

☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars

How much or many packs per day?

# of years? Or year quit?

FAMILY HISTORY - HAS ANY MEMBER OF YOUR FAMILY (PARENT, SIBLING OR GRANDPARENT) HAD ANY OF THE FOLLOWING. PLEASE CHECK YES OR NO.

CANCER	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	TYROID	☐ YES	☐ NO
HEART DISEASE	☐ YES	☐ NO	FATHER SNORES	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	MOTHER SNORES	☐ YES	☐ NO
OBESITY	☐ YES	☐ NO	FATHER HAS SLEEP APNEA	☐ YES	☐ NO
SLEEP DISORDER	☐ YES	☐ NO	MOTHER HAS SLEEP APNEA	☐ YES	☐ NO

Patient's Signature: _____ Date:

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LIST ANY SURGICAL OPERATIONS YOU HAVE HAD. PLEASE CHECK YES OR NO.

APPENDECTOMY	☐	YES	☐	NO	LUNG	☐	YES	☐ NO
BACK	☐	YES	☐	NO	NASAL	☐	YES	☐ NO
EAR	☐	YES	☐	NO	PERIODONTAL	☐	YES	☐ NO
GALLBLADDER	☐	YES	☐	NO	THYROID	☐	YES	☐ NO
HEART	☐	YES	☐	NO	TONSILECTOMY	☐	YES	☐ NO
HERNIA REPAIR	☐	YES	☐	NO	UVULECTOMY	☐	YES	☐ NO

PLEASE LIST ANY OTHER SURGICAL OPERATIONS YOU HAVE HAD THAT ARE NOT MENTIONED ABOVE:

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HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?
PLEASE CHECK YES OR NO AND PROVIDE THE DATE OF WHEN YOU LAST HAD THEM.

MEDICAL CONDITION	CHECK YES OR NO	DATE	MEDICAL CONDITION	CHECK YES OR NO	DATE
Acid Reflux	☐ YES ☐ NO		Injury to mouth	☐ YES ☐ NO	
Adenoids removed	☐ YES ☐ NO		Injury to neck	☐ YES ☐ NO	
Anemia	☐ YES ☐ NO		Insomnia	☐ YES ☐ NO	
Arteriosclerosis	☐ YES ☐ NO		Intestinal disorders	☐ YES ☐ NO	
Artificial hip or prosthesis	☐ YES ☐ NO		Jaw joint surgery	☐ YES ☐ NO	
Asthma	☐ YES ☐ NO		Kidney problems	☐ YES ☐ NO	
Autoimmune disorder	☐ YES ☐ NO		Liver disease	☐ YES ☐ NO	
Bleeding easily	☐ YES ☐ NO		Menstrual cramps	☐ YES ☐ NO	
Blood pressure - high	☐ YES ☐ NO		Multiple sclerosis	☐ YES ☐ NO	
Blood pressure - low	☐ YES ☐ NO		Muscle aches	☐ YES ☐ NO	
Bruising easily	☐ YES ☐ NO		Muscle shaking (tremors)	☐ YES ☐ NO	
Cancer	☐ YES ☐ NO		Muscle spasms or cramps	☐ YES ☐ NO	
Chemotherapy	☐ YES ☐ NO		Muscular dystrophy	☐ YES ☐ NO	
Chronic cough	☐ YES ☐ NO		Nasal allergies	☐ YES ☐ NO	
Chronic fatigue	☐ YES ☐ NO		Needing extra pillows to help breathe at night	☐ YES ☐ NO	
Chronic pain	☐ YES ☐ NO		Nervous system irritability	☐ YES ☐ NO	
Cold hands and feet	☐ YES ☐ NO		Nervousness	☐ YES ☐ NO	
COPD	☐ YES ☐ NO		Neuralgia	☐ YES ☐ NO	
Depression	☐ YES ☐ NO		Numbness of fingers	☐ YES ☐ NO	
Diabetes	☐ YES ☐ NO		Osteoarthritis	☐ YES ☐ NO	
Difficulty concentrating	☐ YES ☐ NO		Ovarian cysts	☐ YES ☐ NO	
Difficulty sleeping	☐ YES ☐ NO		Parkinson's disease	☐ YES ☐ NO	
Dizziness	☐ YES ☐ NO		Poor circulation	☐ YES ☐ NO	
Emphysema	☐ YES ☐ NO		Prolonged bleeding	☐ YES ☐ NO	
Epilepsy	☐ YES ☐ NO		Psychiatric care	☐ YES ☐ NO	
Excessive thirst	☐ YES ☐ NO		Radiation treatment	☐ YES ☐ NO	
Fibromyalgia	☐ YES ☐ NO		Respiratory disease	☐ YES ☐ NO	
Frequent cough	☐ YES ☐ NO		Rheumatic fever	☐ YES ☐ NO	
Frequent illness	☐ YES ☐ NO		Rheumatoid arthritis	☐ YES ☐ NO	
Frequent stressful situations	☐ YES ☐ NO		Scarlet fever	☐ YES ☐ NO	
General anesthesia	☐ YES ☐ NO		Scoliosis	☐ YES ☐ NO	
Glaucoma	☐ YES ☐ NO		Shortness of breath	☐ YES ☐ NO	
Gout	☐ YES ☐ NO		Sinus problems	☐ YES ☐ NO	
Hay fever	☐ YES ☐ NO		Skin disorder	☐ YES ☐ NO	
Healing complications	☐ YES ☐ NO		Sleep apnea	☐ YES ☐ NO	
Hearing impaired	☐ YES ☐ NO		Slow healing sores	☐ YES ☐ NO	
Heart attack	☐ YES ☐ NO		Speech difficulties	☐ YES ☐ NO	

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PLEASE CHECK YES OR NO AND PROVIDE THE DATE OF WHEN YOU LAST HAD THEM.

MEDICAL CONDITION	CHECK YES OR NO	DATE	MEDICAL CONDITION	CHECK YES OR NO	DATE
Heart disorder	☐ YES ☐ NO		Stroke	☐ YES ☐ NO	
Heart murmur	☐ YES ☐ NO		Swelling in ankles or feet	☐ YES ☐ NO	
Heart pacemaker	☐ YES ☐ NO		Swollen, stiff or painful joints	☐ YES ☐ NO	
Heart palpitations	☐ YES ☐ NO		Tendency for ear infections	☐ YES ☐ NO	
Heart value replacement	☐ YES ☐ NO		Tendency for colds	☐ YES ☐ NO	
Hemophilia	☐ YES ☐ NO		Tendency for sore throats	☐ YES ☐ NO	
Hepatitis	☐ YES ☐ NO		Thyroid disorder	☐ YES ☐ NO	
High blood pressure	☐ YES ☐ NO		Tired muscles	☐ YES ☐ NO	
Hypertension	☐ YES ☐ NO		Tonsils removed	☐ YES ☐ NO	
Hypoglycemia	☐ YES ☐ NO		Tumors	☐ YES ☐ NO	
Immune system disorder	☐ YES ☐ NO		Urinary disorders	☐ YES ☐ NO	
Injury to face	☐ YES ☐ NO				

Patient's Signature: _____ Date: _____

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DENTAL HISTORY

Are your teeth sensitive to:

Heat?	Yes	No
Cold?	Yes	No
Sweets?	Yes	No
Biting Pressure?	Yes	No

Does food constantly get stuck in between certain teeth? Yes No

Are you dissatisfied with your teeth in any way? Yes No

Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. Yes No

Do you have any fillings that show in your front teeth? Yes No

Do any of your fillings show when you smile? Yes No

If any of your mercury amalgam fillings need replacement, would you prefer a more natural, tooth-colored restoration? Yes No

Have you ever had any teeth removed? Yes No

If so, how long have these teeth been missing?

Do your gums bleed when you brush? Yes No

Do you ever avoid any part of your mouth when brushing? Yes No

Have you been instructed on proper home care? Yes No

Do you have an unpleasant taste or odor in your mouth? Yes No

Do you smoke? Yes No

Do you frequently snack on sweets between meals or chew gum? Yes No

Do you want to learn to control dental disease and retain your teeth? Yes No

Has the fear of discomfort kept you from regular dental visits? Yes No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No

Have you had your wisdom teeth removed? Yes No

If yes, when?

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DENTAL HISTORY (CON'T)

When was your last dental appointment?

What did you have done?

How often do you brush your teeth?

How often do you floss?

How long since your last *thorough* examination with full mouth x-rays?

What prompted you to seek dental care at this time?

Why did you leave your last dentist?

In your own words, please describe what you feel are your main dental problems. Please describe most important first?

How and when did your problem(s) first begin?

Have you received any injury such as a blow, concussion, or whiplash? If so, when?

Are you restricted in your work or unable to work? ◯ Yes ◯ No

Have you had any assessments or consults? If so, with who and when?

What treatment, if any, have you received by health professionals or others?

Patient's Signature: _____ Date:

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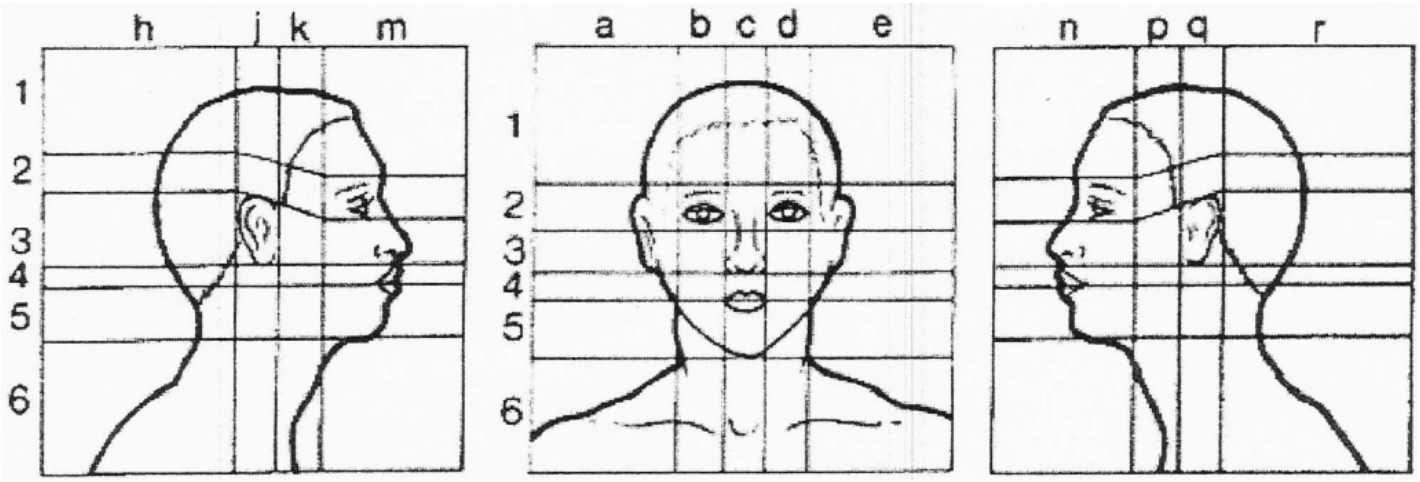
DENTAL HISTORY (CON'T)

What were your treatment results? Were they helpful or not?

What medication are you currently taking?

Please place a mark to indicate where you feel pain or discomfort:



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We would appreciate your assistance in completing this confidential health evaluation form. The information obtained from you will allow us to assess more accurately the nature of your problem(s). Please circle YES or NO, where several symptoms are mentioned, please select those that apply to you.

	CHECK YES OR NO	Office Use Only
Do you notice a burning sensation on your tongue?	YES NO	
Do you notice any impairment of your sense of taste?	YES NO	
Is swallowing difficult at times?	YES NO	
Do you have occasional difficulties with speech?	YES NO	
Do you smoke? If so, how many times per day?	YES NO	
Do you have earaches? Left Right Both	YES NO	
Do you notice a buzzing, ringing, or whooshing noise in your ears? Freq. Occas. Rarely	YES NO	
Do you notice a loss of hearing?	YES NO	
Do you notice increased sensitivity to noise?	YES NO	
Do you notice fullness, stuffiness, or itching of the ears?	YES NO	
Do you ever feel a loss of balance?	YES NO	
Do you ever feel dizzy or nauseous?	YES NO	

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	CHECK YES OR NO	Office Use Only
Do you ever "blackout" temporarily?	YES NO	
Do you experience deep pain behind the eyes?	YES NO	
Do you have a stiff neck or shoulders? Freq. Occas. Rarely	YES NO	
Do you have upper or lower back problems?	YES NO	
Do you have tingling or numbness in the hands or feet?	YES NO	
Do you have joint pain elsewhere in your body? Where?	YES NO	
Do you suffer from Rheumatoid or Osteoarthritis?	YES NO	
Do you have very flexible joints throughout the body?	YES NO	
Do you have headaches? If so, where? Left Right Frt. Bk.	YES NO	
Would you describe your headaches as: Dull Shrp Throb Pierce Ache	YES NO	
Are your headaches worse when lying down?	YES NO	
How frequently do your headaches occur?		

Patient's Signature: _____ Date: _____

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	CHECK YES OR NO	Office Use Only
When do your headaches occur most often? ○ Morn. ○ Noon ○ Eve.	○ YES ○ NO	
Is there anything that seems to cause these headaches?	○ YES ○ NO	
Do you have any clicking or popping noises in your jaw (when/where)? ☐ Opening your mouth ☐ Closing your mouth ☐ Chewing ○ Left Side ○ Right Side ○ Both	○ YES ○ NO	
Does your jaw ever lock when: Trying to open or when fully open?	○ YES ○ NO	
Is your jaw sore or stiff when you wake up?	○ YES ○ NO	
Is there pain or discomfort when you open your mouth?	○ YES ○ NO	
Do you have difficulty making your teeth fit together?	○ YES ○ NO	
Do you clench or grind your teeth?	○ YES ○ NO	
Do you have tooth pain or discomfort in your mouth?	○ YES ○ NO	
Is it difficult or painful to chew hard foods?	○ YES ○ NO	
Have you had orthodontic treatment?	○ YES ○ NO	
Do you have facial pain or discomfort?	○ YES ○ NO	

Please sign below: I certify that the medical history information is complete and accurate.

Patient's Signature: _____ Date: _____

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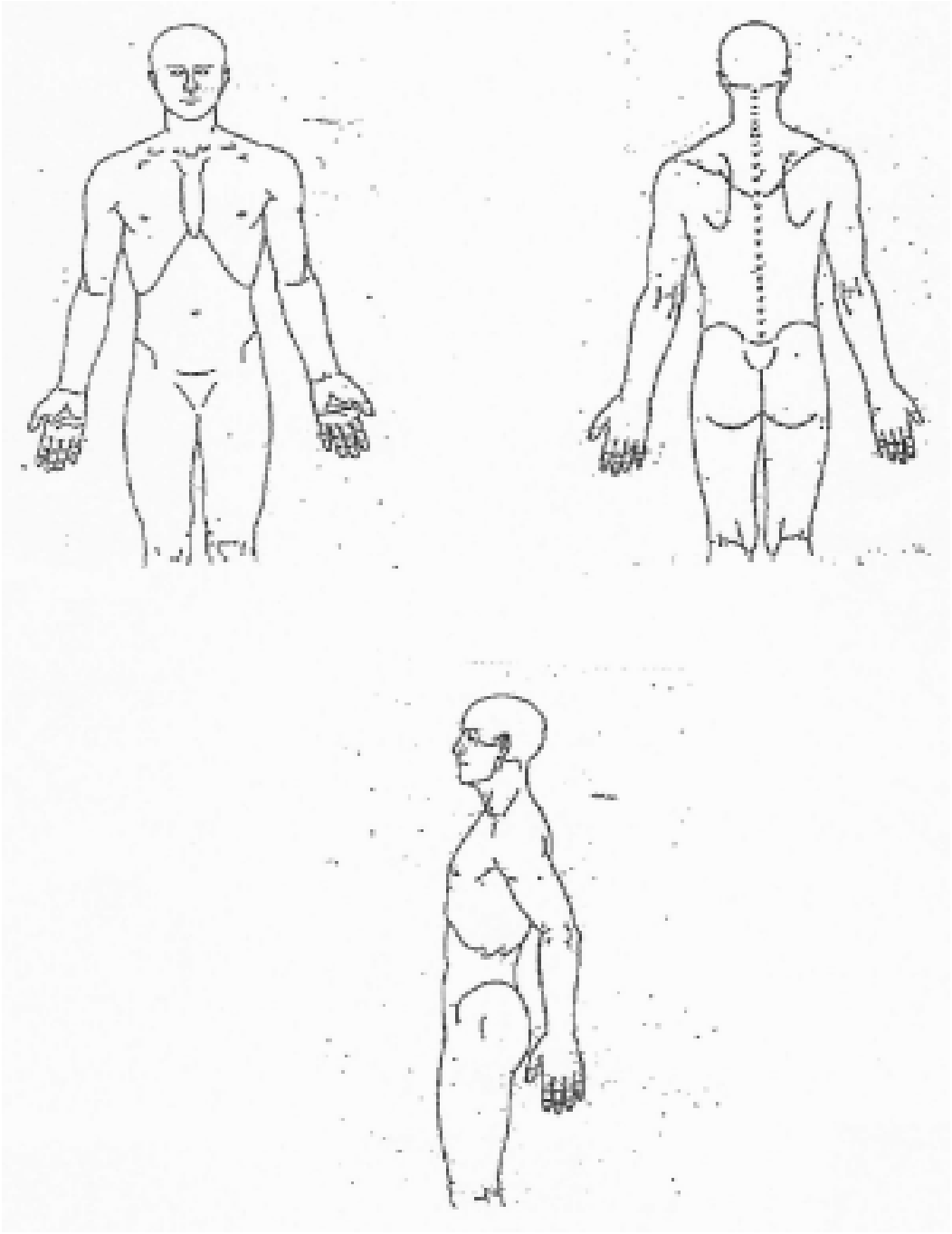
Please place a mark to indicate where you feel pain or discomfort:



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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Emergency Contact: _____

Home Phone: _____ Work Phone: _____

I fully understand that I am responsible for all fees incurred from treatment provided by Maribel M. Vann, D.D.S. If payment on my account is not made in a "timely" manner, I hereby authorize **Dr. Maribel M. Vann** to charge my credit card for any outstanding balance after 60 days.

Visa / Mastercard Cardholder: _____

Account #: _____ Exp Date: _____

Signature: _____

I fully understand that Dr. Vann may retain the services of an attorney and / or collection agency to assist with the collection of any outstanding balance pertaining to my account.

I further understand that any expenses incurred by Dr. Vann to collect a delinquent account, will become an additional responsibility of mine, the patient.

Print Name: _____

Signature: _____ Date: _____

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All suck requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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OUR MUTUAL AGREEMENT

COMMITMENT TO APPOINTMENT

Dr. Vann and her staff reserve time for each individual patient as we only treat one patient at a time and your time is exclusively reserved for you. We will be here fully prepared to serve you and we trust that when you put your name in our appointment book that it is your bond of trust that you will be here. We do not accept nor honor short-notice changes. This agreement indicates that we have mutual respect for each other's time.

COMMITMENT TO TREATMENT

As a committed professional I believe I have a responsibility to use my best care, skill and judgment in planning and executing your treatment. I believe that all treatment, once it is begun should be completed. Incomplete treatment leads to further damage, loss of teeth, problems, complications and misunderstandings. Even if we create a Health Path and a Plan that we will complete over time, it is necessary that it be completed as soon as possible. Conditions change, disease advances.

COMMITMENT TO FINANCIAL AGREEMENT

By signing below, you have indicated that you agree that all fees should be properly explained to you and you agree to fulfill your financial commitment to our practice promptly and completely. Your financial responsibility is not dependent upon any decisions made by your insurance carrier.

INFORMED CONSENT

Restorative and prosthetic treatment is designed to preserve teeth and preserve your oral and general health. Restorative treatment when completed on patients who have accepted their responsibility to do their own home care, together with creating a proper bite relationship and occlusion can last nearly a lifetime. On the other hand, there is always risk of infection, swelling, discomfort, and some post-operative discomfort.

After reading the preceding risks that may occur in connection with this procedure, consent is granted for Dr. Maribel M. Vann to administer anesthetics and medications and treat as deemed necessary for the release of any information relating to treatment. Please ask Dr. Vann if you have questions concerning this information.

We appreciate your confidence in choosing us to work with you to create a Health Path. We are committed to solid, caring relationships with our patients and believe that honest communication regarding your care will enhance our relationship.

Signature - Patient / Legally Responsible Person: _____ Date: _____

Doctor: _____ Witness: _____ Date: _____