PROVIDENCE PROSTHODONTICS
1310 W. Stewart Drive, Suite 202
Orange, CA 92868

PATIENT PROVIDED TMJ HISTORY

INITIAL EXAMINATION AND CONSULTATION

In an effort to better care for your specific needs, we ask that you provide us with a brief description of the dental problem or symptoms, which you are experiencing. Please indicate the appropriate date of onset of symptoms in the space provided below. On the back of this page please list in detail and in chronological order the names of the dentists, physicians, neurologists, otolaryngologists, physical therapists, chiropractors, or other health care providers who have examined and/or treated you for the stated symptoms.

Onset: Approximate date of onset of symptoms which motivated you to seek care: ___________________.

If your symptoms are long term, when did you first notice symptoms? __________________________.

Chief Concern: List the one or two symptoms which are your greatest concern followed by the additional symptoms.

Chief Concern: 1)

2)

Additional Symptoms:

Brief Narrative History (Use additional pages if necessary):

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HISTORY OF PRIOR TMJ TREATMENT

DATE TREATED	PRIOR HEALTH CARE PROFESSIONALS
1. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________
2. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________
3. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________
4. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________
5. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________
6. From: ____________	Name ____________________
To: ____________	City and State ____________________
	Comments ____________________

USE ADDITIONAL PAGE IF NECESSARY

You have my consent to send written reports of my examination findings and proposed treatment to any of the above stated health care professionals (optional) unless otherwise noted. I also consent to having information relative to my history, treatment and treatment outcome, collected and included in dental research and publications for scientific investigation and education provided my name is not revealed in said publications.

Signature: ______________________________ Date: ____________________

For Office Use Only

Prior Therapy:	#	DDS	RTH	OMS	TMJ	DC	PTr	VTS	MDG	NRL	ENT	PSY	MRI	CAT

History: Of splints # and date	

RTH-orthodontist OMS-oral surgeon DC-chiropractor PTr- physical therist VTS- cobined # of PTr & DC visits
MDG- medical provider NRL- neuriologist ENT- ear nose & thrort PSY- psychiatrist