Jennifer Buchanan, D.D.S. Registration **1601 2nd St, Ste 103-B, San Rafael, CA 94901 415-460-1601**

Patient Information:

Patient Name: ☐ Female ☐ Male

Address: Street City Zip Code

Home phone: Work phone: Cell phone:

Date of Birth: Email address:

Full time student? ☐ Yes ☐ No Name of school:

Occupation/Employment: Employer:

Height: Weight:

☐ Married ☐ Partner ☐ Single ☐ Separated ☐ Divorced ☐ Widow/Widower

Emergency contact person: Home phone:

Relationship to patient: Work/cell phone:

Referred by: Phone:

Address:

Responsible Party (if not patient):

Relationship to patient: Phone:

Insurance Carrier:

If you have an attorney for a legal proceeding involving the problem that brought you to see me, please complete:

Attorney's name: Law firm:

Address: Phone:

Primary Care Provider: ..... Degree: ..... Specialty: .....

Address: .....

Phone: ..... Fax: ..... Date of last visit: .....

Are you under active treatment by this doctor? ..... If yes, for what condition(s): .....

.....

Has this doctor prescribed any medications recently? ..... (If yes, please list in “Medications” form)

General Dentist: ..... Degree: ..... Specialty: .....

Address: .....

Phone: ..... Fax: ..... Date of last visit: .....

Are you under active treatment by this doctor? ..... If yes, for what condition(s): .....

.....

Has this doctor prescribed any medications recently? ..... (If yes, please list in “Medications” form)

Other Heath Practitioners: ..... Degree: ..... Specialty: .....

Address: .....

Phone: ..... Fax: ..... Date of last visit: .....

Are you under active treatment by this doctor? ..... If yes, for what condition(s): .....

.....

Has this doctor prescribed any medications recently? ..... (If yes, please list in “Medications” form)

Other: .... Degree: .... Specialty: ....

Address: ....

Phone: .... Fax: .... Date of last visit: ....

Are you under active treatment by this doctor? .... If yes, for what condition(s): ....

....

Has this doctor prescribed any medications recently? .... (If yes, please list in "Medications" form)

Other: .... Degree: .... Specialty: ....

Address: ....

Phone: .... Fax: .... Date of last visit: ....

Are you under active treatment by this doctor? .... If yes, for what condition(s): ....

....

Has this doctor prescribed any medications recently? .... (If yes, please list in "Medications" form)

Other: .... Degree: .... Specialty: ....

Address: ....

Phone: .... Fax: .... Date of last visit: ....

Are you under active treatment by this doctor? .... If yes, for what condition(s): ....

....

Has this doctor prescribed any medications recently? .... (If yes, please list in "Medications" form)

Health History

Medications and Drugs

Note: Many substances such as over-the-counter medicines, prescribed medications, recreational drugs, etc., have profound side-effects on the jaw joints and muscles. It is extremely important that we know everything you are taking or using. Please be assured that we keep our records strictly confidential.

Pharmacy Name: ..... Phone: .....

Address: .....

Current Prescription Medications:

1. Medication:	**Prescribe by Dr.:**	**For what condition:** .....
Freqency:	**Dosage:**	**Long term?** .....
2. Medication:	**Prescribe by Dr.:**	**For what condition:** .....
Freqency:	**Dosage:**	**Long term?** .....
3. Medication:	**Prescribe by Dr.:**	**For what condition:** .....
Freqency:	**Dosage:**	**Long term?** .....
4. Medication:	**Prescribe by Dr.:**	**For what condition:** .....
Freqency:	**Dosage:**	**Long term?** .....

Over-The-Counter Remedies

1. Medicine:	**Amount:**	**How often?**	**Reason for taking?**
2. Medicine:	**Amount:**	**How often?**	**Reason for taking?**
3. Medicine:	**Amount:**	**How often?**	**Reason for taking?**

Recreational and Non-remedy substances

	Amount:	**How Often?**	**How long have you used it?**
1. Caffeine:			
2. Alcohol:			
3. Cigarettes:			
4. Other			

Allergies and Adverse Reactions to Medications

.....

History of Medical Conditions and Illness

Please circle the appropriate response for each of the following. **N**= Never **P**= Previously **C**=Currently have/had this condition.

ARTHRITIS

Rheumatoid	N	P	C
Osteoarthritis	N	P	C
Other:_____	N	P	C

ARTIFICIAL IMPLANTS

Joint prosthesis	N	P	C
Pacemaker	N	P	C
Heart valve	N	P	C

BLOOD DISORDERS

Bleeding tendencies	N	P	C
Anemia	N	P	C
Leukemia	N	P	C

ENDOCRINE (GLAND) DISORDERS

Diabetes	N	P	C
Thyroid disease	N	P	C

EYE DISORDERS

Glaucoma	N	P	C
Ocular Herpes	N	P	C

HEADACHE

Tension headache	N	P	C
Migraine headache	N	P	C
Unexplained headaches	N	P	C

HEART DISORDERS

Coronary artery disease	N	P	C
Heart murmur	N	P	C
High blood pressure	N	P	C
Congestive heart failure	N	P	C

OTHER CONDITIONS

Autoimmune disorders	N	P	C
Osteoporosis	N	P	C
Psychological difficulties	N	P	C
Tumors or malignancies	N	P	C
Venereal disease	N	P	C
Radiation treatment	N	P	C
Recent excessive weight gain	N	P	C

KIDNEY, URINARY DISORDERS

Kidney disease	N	P	C
Bladder infections	N	P	C

LIVER DISEASE

Hepatitis	N	P	C
Cirrhosis	N	P	C

LUNG DISORDERS

Asthma	N	P	C
Emphysema	N	P	C
Lung cancer	N	P	C

MUSCLE DISORDERS

Muscle tension	N	P	C
Muscular dystrophy	N	P	C
Frequent muscle spasms	N	P	C

NERVE DISORDERS

Cerebral palsy	N	P	C
Epilepsy	N	P	C
Neuralgia	N	P	C
Multiple sclerosis	N	P	C
Stroke	N	P	C
Parkinson's disease	N	P	C

NIGHTTIME OR SLEEP CONDITIONS

Insomnia	N	P	C
Nighttime sweating	N	P	C
Needing extra pillows to help breathing at night	N	P	C
Heart pounding or beating irregularly at night	N	P	C
Morning dry mouth	N	P	C
Heartburn or sour taste in the mouth at night	N	P	C

STOMACH, INTESTINAL DISORDERS

Ulcers	N	P	C
Colitis	N	P	C
Irritable bowel	N	P	C
GERD	N	P	C

WOMEN

Are you pregnant?	No	Yes
Regular menses?	No	Yes

Other medical conditions and illness:

.....

.....

.....

.....

.....

.....

History of Dental Conditions and Treatment

Has your experience with dentists been ☐ Favorable? ☐ Unfavorable?

How much dental work have you had? ☐ Extensive ☐ Routine ☐ Minimal

Would you say your mouth is ☐ Healthy? ☐ Average? ☐ Has a lot of problems?

Is your bite comfortable? ☐ Yes ☐ No

Do you do any of the following? ☐ Chew gum? ☐ Daytime clenching? ☐ Grind or clench teeth during sleep?
☐ Lip biting? ☐ Tongue Bracing? ☐ Grind or clench teeth during the day?
☐ Other? .....

Please check all of the following types of dental care you may have received:

☐ Endodontics (root canal) ☐ Oral surgery ☐ Dentures or partials
☐ Periodontics (treatment of gums) ☐ Restorations (fillings) ☐ Dental implants
☐ Orthodontics ☐ Crowns/bridges ☐ Extensive bite adjustment

Other dental concerns?

History of Injuries and Trauma

Have you ever been seriously injured? ☐ **Yes** (If so, please complete this section.) ☐ **No**

1. Cause of injury: ..... Date of injury: .....

Description of injury: .....

Amount of recovery: ☐ Complete ☐ More than half ☐ Less than half Time to recover: .....

2. Cause of injury: ..... Date of injury: .....

Description of injury: .....

Amount of recovery: ☐ Complete ☐ More than half ☐ Less than half Time to recover: .....

Surgical History

How many major surgeries have you had? ..... **Please describe (most recent surgery first):**

1. Reason for surgery: ..... Date of surgery: .....

Description of surgery: .....

Amount of recovery: ☐ Complete ☐ More than half ☐ Less than half Time to recover: .....

2. Reason for surgery: ..... Date of surgery: .....

Description of surgery: .....

Amount of recovery: ☐ Complete ☐ More than half ☐ Less than half Time to recover: .....

SLEEP QUESTIONS:

Check the following symptoms which apply to you:

___ Nocturnal teeth grinding
___ Daytime teeth clenching
___ Jaw pain
___ Facial pain
___ Jaw clicking
___ Head pain
___ Neck pain
___ Limited opening, jaw locking
___ Snoring
___ Difficulty speaking
___ Difficulty swallowing
___ Significant daytime drowsiness
___ Difficulty falling asleep
___ Morning hoarsness
___ Feeling unrefreshed in the morning
___ I have been told that "I stop breathing when sleeping"
___ Morning headache
___ Waking up frequently
___ Poor sleep
___ Nighttime choking spells
___ Gasping when waking up

Anything else?: _____

_____

SLEEP APNEA QUESTIONS (Skip if does not apply)

Have you ever had a sleep study for sleep apnea? ___Yes ___No If yes, please describe:

Sleep study location:_____ Date of study:_____

Was CPAP (or BiPAP) prescribed? ___Yes ___No Are you currently using CPAP? ___Yes___No

If you have attempted to use CPAP but could not tolerate it because:_____

_____

Bed Partner Questions: ___I sleep by myself (no bed partner)

Completed by: _____(name) _____(relationship)

Please have your bed partner describe your sleep. Comment on any snoring, witnessed pauses in breathing, noisy breathing, leg movements and the frequency of these events or triggers such as alcohol, sleeping on the back, etc.

_____

_____

Epworth Sleepiness Scale:
To rate your degree of sleepiness during the day, please indicate how likely you are to doze off or fall asleep during the day in the following situations, in contrast to feeling just tired:

0 = NEVER 1 = SLIGHT CHANCE 2 = MODERATE CHANCE 3 = HIGH CHANCE

____ Sitting and reading
____ Sitting quietly after lunch without alcohol
____ As a passenger in a car for an hour without a break
____ Watching TV
Sitting, inactive in a public place (i.e. theater) ____
Lying down to rest in the afternoon ____
Sitting and talking with someone ____
In a car, while stopped for a few minutes in traffic ____

Total: ____

Physical Problems and Symptoms

Please rank you physical problem(s) below in order of importance:

1.

2.

3.

4.

5.

Circle the number that best represents you pain this past week:

	None			Mild			Moderate			Severe			Extreme
Jaw or face pain	0	1	2	3	4	5	6	7	8	9	10		
Jaw or face Tightness	0	1	2	3	4	5	6	7	8	9	10		
Headaches	0	1	2	3	4	5	6	7	8	9	10		
Neck pain	0	1	2	3	4	5	6	7	8	9	10		
Tooth pain	0	1	2	3	4	5	6	7	8	9	10		

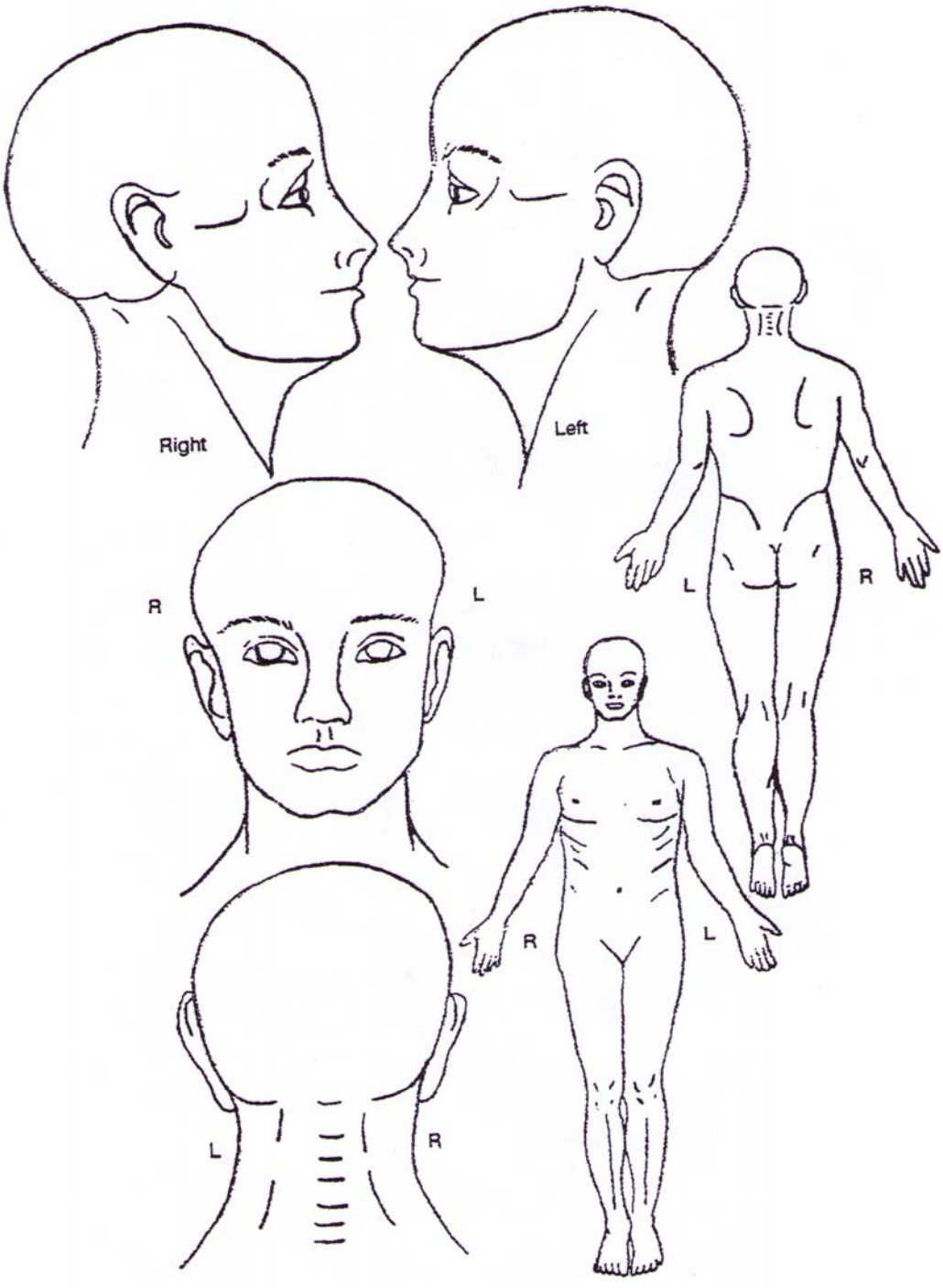
Circle the number that best represents the difficulty/discomfort with the following activities:

	None			Mild			Moderate			Severe			Extreme
Talking	0	1	2	3	4	5	6	7	8	9	10		
Yawning	0	1	2	3	4	5	6	7	8	9	10		
Prolonged Opening	0	1	2	3	4	5	6	7	8	9	10		
Eating soft foods	0	1	2	3	4	5	6	7	8	9	10		
Eating hard foods	0	1	2	3	4	5	6	7	8	9	10		
Sleeping	0	1	2	3	4	5	6	7	8	9	10		
Other	0	1	2	3	4	5	6	7	8	9	10		

Please describe other difficult activity: .....

Specific Areas of Pain

Please use the diagram to mark the area(s) where you experience pain.



Jennifer Buchanan, D.D.S.

Directions to **1601 2nd Street, San Rafael, CA 94901, PHONE: 415-460-1601 FAX: 415-460-1606**

From North:
Take 101 South to **Central San Rafael exit**.
Right on **3rd** Street…

From South:
Take 101 North to **Central San Rafael exit**.
Left on **3rd** Street…

From East Bay:
Take **Richmond/San Rafael Bridge** to **101 North**, take **Central San Rafael** Exit.
Left on **3rd** Street...

Stay on **3rd** Street (one way street) through several lights (about 1/2 mile).
Left on **Shaver** Street (the light after E St.).
Right on **1st** Street.
Go to the end of 1st Street, Dr. Buchanan's office is on the right. There is parking around the building and in a parking lot across the street on Miramar Avenue.

Go through the black iron gate to the end of the covered walkway (on the Miramar Ave. side of building), the office is on your right.