Tad Morgan, DDS
Family Dentistry & Tyler Headache Center
16409 FM 344 West • Bullard, TX 75757
Phone: (903)825-1112 • Fax: (903)598-7894

Welcome to our office!

Date:_____

Name (Last, First, MI):_____ Birth Date:_____
Preferred Name:_____ Email: _____
Street Address: _____City, State: _____
Zip Code:_____ Home Phone: _____ Cell: _____
Social Security #: _____ Drivers License #:_____State: _____
Marital Status (check one): Δ Single Δ Married Δ Separated Δ Divorced Δ Widowed
Employer: _____Occupation:_____ Work Phone: _____
Spouse's Name (Last, First, MI): _____ Birth Date _____
Spouses Employer_____ Work Phone: _____
Emergency Contact (Name, Telephone, Relation):_____
Who may we thank for referring you? (Friend, web, radio, etc):_____

◊ Head of Household Information (If Self, then write "self" and skip this portion)
Name of person responsible for account (Last, First, MI):_____
Birth Date: _____ Phone: _____ Social Security #: _____
Relation to patient: _____ Employer:_____ Work Phone: _____
Street Address: _____ City, State, Zip: _____
Drivers License #:_____ State: _____

◊ Medical History
Have you ever had, or do you currently have any of the following? (Check all that apply)

Δ Asthma
Δ Arthritis
Δ Artificial Joints
Δ Anxiety/Nervous Disorder
Δ Alcohol/Drug Addiction
Δ Blood Transfusion
Δ Back/Neck Problems
Δ Cosmetic Surgery
Δ Cancer/Chemotherapy
Δ Diabetes
Δ Epilepsy/Seizures
Δ Fainting / Dizziness
Δ High Blood Pressure
Δ Heart Murmur
Δ Heart Disease
Δ Heart Attack
Δ Mitral Valve Prolapse
Δ Glaucoma
Δ Hemophilia/Excessive Bleeding
Δ Hepatitis Type _____
Δ HIV/AIDS Test Positive
Δ Herpes/Cold Sores
Δ Head Injury/Mental Disorder
Δ Headaches/Migraines
Δ Ulcers
Δ Stroke
Δ Snoring
Δ Sleep Apnea
Pacemaker
Δ Rheumatic Fever
Δ Tuberculosis
Δ Respiratory Problems
Δ Sinus Problems
Δ Stomach Problems
Δ Kidney Disease
Δ Liver Disease
Δ Thyroid Disease
Δ Venereal Disease

Please list any other conditions not listed above: _____

Are you allergic to, or have you had any adverse reactions to any of the following? (Check all that apply)

Δ Aspirin	Δ Latex	Δ Hydrocodone
Δ Codeine	Δ Local Anesthetic	Δ Sulfa Drugs
Δ Epinephrine	Δ Nitrous Oxide (Laughing Gas)	Δ Tetracycline
Δ Erythromycin	Δ Penicillin	Δ Valium

Other allergies:_____
Do you smoke or chew tobacco? Δ YES Δ NO If so, how much? _____
Physician's Name: _____ Telephone #: _____
Date of Last Physical Exam: _____
What medications are you taking? _____
_____
Have you been hospitalized in the past two years? Δ YES Δ NO
If yes, for what reason? _____
Are you currently under the care of a physician for a specific condition? Δ YES Δ NO
If yes, please describe: _____
If you are a female: Are you pregnant? Δ YES Δ NO Δ MAYBE If yes, how many months? _____
Are you taking birth control pills? Δ YES Δ NO

◊ Dental History
Name of Previous / Present Dentist: _____ Date of Last Visit: _____
Location of this Dentist (City/State): _____ Telephone #:_____
How many times a day do you brush your teeth? _____ How often do you floss? _____
Are you currently in dental-related pain? Δ YES Δ NO Do you frequency experience jaw pain? Δ YES Δ NO
Do you have difficulty becoming numb for dental treatment? Δ YES Δ NO Δ UNSURE
Do you have dental-related anxiety? Δ YES Δ NO
Are you happy with the appearance of your smile? Δ YES Δ NO
If no, please tell us what you would like to change (color, shape, alignment, etc.):_____
_____

Please number the following in the order in which each would keep you from having dental treatment:
____ Fear of Pain ____ Cost of treatment ____ Lack of concern ____ Missing work

◊ Consent for Treatment
The undersigned, (print name) _____, hereby confirms that the above information is correct to the best of his/her knowledge. I understand that the information given will be used by the doctor to help determine appropriate and healthful dental treatment for this patient. If there is any change in this patient's medical status, I agree to inform the dentist or a member of his team. Furthermore, I authorize the doctor to take x-rays, photographs, study models, T-Scan bite analysis, joint vibration analysis (JVA), Electromyography (EMG), and/or any other diagnostic aids he deems appropriate in order to make a thorough diagnosis of this patient's dental needs. I also authorize the doctor to choose and employ such assistance as he deems fit. I give my consent for the doctor to use any and all forms of treatment and therapy necessary, including prescribing or administering medications that may be indicated in connection with this patient, to be determined and discussed on an appointment-to-appointment basis. I understand that the use of anesthetic agents embodies a certain risk.

_____ _____
Patient Signature (Parent or Guardian Signature) Date

Parent or Guardian's Name Printed (if applicable): _____ Relation: _____

Tad Morgan, DDS
Family and Restorative Dentistry
16409 FM 344 West • Bullard, TX 75757
Phone: (903)825-1112 • Fax: (903)598-7894

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

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

_____	_____	_____
Patient/Guardian Signature	**Patient/Guardian Printed Name**	**Date**

I authorize Tad Morgan, DDS & The Tyler Headache Center to discuss and release my medical information to:

_____	_____	___ _____
Name	Relationship to patient	Phone
_____	_____	___ _____
Name	Relationship to patient	Phone

Please DO NOT release my medical information to:

_____	_____	___ _____
Name	Relationship to patient	Phone
_____	_____	___ _____
Name	Relationship to patient	Phone

_____	_____	_____
Patient/Guardian Signature	**Patient/Guardian Printed Name**	**Date**

_____

FOR OFFICE USE ONLY

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

- o Individual refused to sign
- o Communication barriers
- o An emergency situation
- o Other (specify):

_____

Tad Morgan, DDS
Family Dentistry & Tyler Headache Center
16409 FM 344 West • Bullard, TX 75757
Phone: (903)825-1112 • Fax: (903)598-7894

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INOFMATION.

PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice is in effect NOW and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information created or received before we made these changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed on this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection to our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you make revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death, If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement of your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your heath or safety or to the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages, emails, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by sing the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $__ for each page, $___ per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information on this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before September 10, 2009. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (-email), you are entitled to receive this Notice in written form.

TruDenta®

HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? » More on the: ☐ Left ☐ Right ☐ Equal » More on the: ☐ Front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer ☐ NTI ☐ Sleep Appliance	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Tooth Loss ☐ Crowns	☐ Yes	☐ No
8	Have you been in a motor vehicle accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-3 Months ☐ 3-12 Months ☐ More than 1 year » Did you hit your head? ☐ Head Injury ☐ Whiplash ☐ Concussion ☐ Car ☐ ATV ☐ Motorcycle ☐ Bicycle ☐ Other _____	☐ Yes	☐ No
9	Have you had other head/neck trauma? ☐ Slip/Fall ☐ Sports Injury ☐ Trauma ☐ Fights/Domestic Violence ☐ Other » When? ☐ 0-3 Months ☐ 3-12 Months ☐ More than 1 year » Type of injury ☐ Head Injury ☐ Concussion ☐ Whiplash ☐ Neck Injury	☐ Yes	☐ No
10	Do you have any postural position problems? ☐ Working at a desk ☐ Sitting at work ☐ Computer/laptop ☐ Commuting	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

#	SYMPTOMS
13	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
14	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
15	How often do you get headaches that make it difficult to function without medication? ☐ Almost Daily ☐ More than once a week ☐ More than once a month ☐ Almost never
16	How often do you get other milder headaches? ☐ Almost Daily ☐ More than once a week ☐ More than once a month ☐ Almost never
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ Somewhat less ☐ A lot worse Got less/worse when _____
	IMPACT ON DAILY LIVING ACTIVITIES
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
19	What is your anxiety level? ☐ Mild ☐ Moderate ☐ Severe
20	What have you missed out upon because of your pain or headaches?*(Check all that apply)* ☐ Days at work ☐ Focus at work ☐ Activities with friends/family ☐ Activities with children ☐ Household chores ☐ Major events
21	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Frustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other _____
22	How many days per month are you: Pain Free? _____ Headache Free? _____
	NOTES: _____

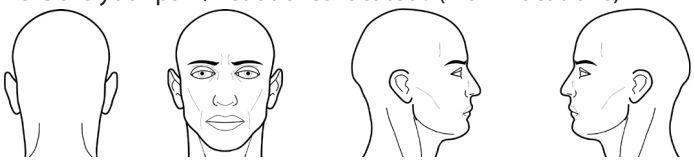
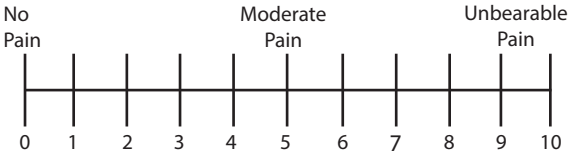
TruDenta®

PAIN/HEADACHE HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS
1	Have you been diagnosed by a health care provider with any of the following? » ☐ Migraine » ☐ Chronic Daily Headache » ☐ Tension Headache » ☐ Cluster Headache » ☐ Medication Overuse Headache » ☐ Menstrual Migraine » ☐ Trigeminal Neuralgia » ☐ Fibromyalgia » ☐ TMJ/D » ☐ Neck Problems » ☐ Other _____
2	What sets off or triggers your pain or headaches? _____
3	What tests have you had to help diagnose your headaches? » ☐ MRI » ☐ CT Scan » ☐ Blood Tests » ☐ Hormone Testing
4	Where are your pain/headaches located? (Mark Locations)  Back Front Right Side Left Side On a scale of 1-10, how painful is it? 
5	Describe the type of headache pain you feel most often: » ☐ Achy » ☐ Throbbing » ☐ Stabbing » ☐ Other _____
6	What other doctors have you seen for your pain, headaches, and/or migraines

☐ GP / FAMILY DOCTOR / OB-GYN	_____	☐ PHYSICAL THERAPIST	_____
☐ DENTIST (IF OTHER)	_____	☐ CHIROPRACTOR	_____
☐ NEUROLOGIST	_____	☐ EAR NOSE THROAT	_____
☐ PSYCHIATRIST/PSYCHOLOGIST	_____	☐ OTHER	_____

7 What medications do you use for headache, migraine, or pain relief?

MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?
Acetaminophen, Tylenol		
Ibuprofen, Advil, Motrin, Nuprin, etc..		
Naproxin, Aleve		
Rx pain medication ( )		
Rx pain medication ( )		
Rx muscle relaxant ( )		
Rx anxiety medication ( )		
Rx depression medication ( )		
Rx migraine medication ( )		
Medication for sleeping ( )		
Caffeine intake ( )		
Alcohol intake ( )		
THC, Medical Marijuana ( )		
Other: ( )		

8 Do you try non-medicating techniques for managing your pain or headaches? ☐ Yes ☐ No

» ☐ Yoga » ☐ Breathing Exercises » ☐ Cold Packs » ☐ Massage » ☐ Meditation » ☐ Physical Therapy » ☐ Hot Packs/ Hot Bath

» ☐ Acupuncture » ☐ Exercise » ☐ Other (please describe) _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE: _____