

**AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO
AGENT (S) UNDER HIPAA AND CALIFORNIA LAW**

I, _____ at _____, grant to

The Dental Trauma Center at 12243 South Hawthorne Blvd, Hawthorne, CA 90250

the authority to receive information and all medical records, reports, and x-rays regarding my health care needs.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC § 1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to the entity named above, as well as, any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s), named above, without restriction, inclusive of means of electronic submission and dissemination (i.e. email, fax, etc.), and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

I understand that I may revoke this authorization at any time by written notice to the covered entity.

This authorization shall expire on the date of my death unless validly revoked prior to that date.

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA regulations, inclusive of redisclosure by means of electronic submission and dissemination,

This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

I have been made aware of and have had an opportunity to read this office's Privacy Practices and understand its terms. I also acknowledge that I may request a copy of said Privacy Practices at any time by written notice to the covered entity.

I have a right to a copy of this authorization.

Date: _____ / _____ /2025

Principal name (Printed)

Signature of Principal

Interpreter

ADA Dental Claim Form

THE DENTAL TRAUMA CENTER

E - M A I L C O N S E N T F O R M

Patient name: _____

Practice Physician: _____

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

- a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Schames and the Practice are not encrypted, so E-mails may not be secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.
- b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- c) E-mail senders can easily misaddress an E-mail.
- d) E-mail is easier to falsify than handwritten or signed documents.
- e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
- f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.
- i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) Practice will/may forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as

authorized or required by law.

- b) Practice may use email as a form of communication with other third parties, physicians and attorney(s) (applicant and defense) as it relates to patient's care and/or the resolution of any outstanding balances owed to Practice.
- c) This consent will remain in effect until terminated in writing by either the patient or Practice.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician(s), other parties, and me, and consent to the conditions and instructions outlined.. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge The Dental Trauma Center and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature _____

Date _____

Witness signature _____

Date _____

09262025

If QME: TIME STARTED: _____ TIME ENDED: _____

Nurse: _____

INTP: _____

CERT #: _____

1

NAME: _____ DATE: ____ / ____ / 202 ____

Primary Treating Physician: Dr. _____

Birth Date: ____ / ____ / ____ MALE FEMALE

Home Tel: () _____ Cell: () _____ Email: _____

Address: _____

Attorney's Name: _____ Attorney's Phone #: _____

1. YES NO Do you have any heart problems?
Murmur Mitral Valve Problem Stent Pacemaker Rheumatic Heart Disease
2. YES NO Do you have any metal joint replacements? (NOT DENTAL FILLINGS)
3. YES NO Do you have High Blood Pressure?
4. YES NO Do you have Diabetes?
5. YES NO Do you feel that stomach acids come up into your mouth or throat?
6. YES NO Do you have any Kidney problems?
7. YES NO Do you have a Thyroid problem?
8. YES NO Do you have or have you had any of the following:
HIV Hepatitis TB VD
9. YES NO Are you taking blood thinners? Which one: _____
10. YES NO Do you have any breathing problems?
Asthma Shortness of Breath
11. YES NO Do you have any numbness or pins / needles feeling anywhere in your body?
Where: _____
12. YES NO Do you have any Liver problems?
13. YES NO Do you have any Urinary problems?
14. YES NO Awakens at night to urinate: _____ times per night
15. YES NO Have you ever had a Sleep Study Test?
When: _____ Apnea Results? YES NO
16. YES NO Have you ever been given a CPAP mask to use at night to help you breathe?
17. YES NO Do you awaken in the morning with a headache in your temple/forehead areas?

History of Allergies: Penicillin Sulfa Erythromycin Seasonal Allergies

Please circle medications you are taking?Pristiq Wellbutrin Effexor Celexa Cymbalta Prozac Lexapro Zoloft Paxil Omeprazole Prilosec
Ibuprofen Motrin Advil Tylenol Aleve Naproxen Naprosyn Flexeril Tramadol HydrocodoneVicodin Norco Oxycodone Ambien Zolpidem Alprazolam Ultram Gabapentin Neurontin Metformin
Glipizide Cyclobenzaprine Hydrochlorothiazide Lisinopril Atenolol Thyroxine Atorvastatin

Medications For: Diabetes Sleep High Blood Pressure Pain Anti-Inflammatory Cholesterol (see attached sheet)

BELOW THE LINE TO BE COMPLETED BY THE DOCTOR:

	DX Pre-Injury	Increased After Injury	DX Post-Injury
Blood Pressure			
Diabetes			
Gastric Acid			
Kidney Problems			
Thyroid Problems Hypo Hyper			

History of Medication Usage

*How many times per Day?

*For how long have they taken the Medication?

What medications were you taking before the work injury?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other _____

What medications are you presently taking?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other _____

What medications were you taking after the work injury (But are no longer taking) How many times per Day? For how long have you taken the medication for?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other _____

Patient to call the office with the names of the medications they take _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing
 It is important that you circle a number (0 to 3) on each of the questions.

Siting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place – for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total Score:

BELOW THE LINE TO BE COMPLETED BY THE DOCTOR:

	<u>Before the Injury</u>	<u>After the Injury</u>
Do you have bad breath?	YES NO	YES NO
What percentage of time do you have bad breath?	(0 to 100%) _____ %	_____ %
How intense is your bad breath?	VAS _____	VAS _____
How often do people tell you that you have bad breath?	VAS _____	VAS _____
Does your bad breath interfere with your ability to interact with other people?	VAS _____	VAS _____
Does your bad breath interfere with your ability to interact with your family?	VAS _____	VAS _____
Does your bad breath interfere with your ability to have intimate Kissing with your significant other?	VAS _____	VAS _____
Does your bad breath cause you embarrassment?	VAS _____	VAS _____
Does your bad breath cause you stress?	VAS _____	VAS _____

I attest that all of the above is true.

Patient's Signature: **X** _____ Date: _____ / _____ /202_____

Halitosis Meter Reading = _____

1 = No Odor 2 = Slight Odor 3 = Moderate Odor 4 =Strong Odor 5 = Intense Odor
 Please circle the following that pertains to you and your injury.

Hand Dominance Right Left

In your work injury, did you injure your:

Right	Shoulder	Arm	Elbow	Wrist	Hand	Fingers
Left	Shoulder	Arm	Elbow	Wrist	Hand	Fingers

Do you have any difficulty using your hands to adequately grip a toothbrush and brush your teeth? Yes No

Do you have any difficulty using hands/fingers to adequately floss your teeth? Yes No

Do you have any difficulty holding a toothpaste tube with one hand and using the other hand to open the toothpaste cap? Yes No

Do you have any difficulty squeezing toothpaste with one hand and holding the toothbrush with the other hand? Yes No

Do you have any difficulty using your hands to cut your food? Yes No

Do you have any difficulty using your hands to feed yourself? Yes No

Do you have any difficulty raising up your arm to comb or brush your hair? Yes No

Patient's Signature: **X** _____ Date: ____ / ____ /202____

Do you Smoke? Yes No

Have you ever smoked? Yes No

When did you stop smoking? _____ months ago _____ years ago

How much do you smoke? _____ cigarettes/day

How many years were you a smoker? _____

Did your smoking usage increase after the industrial injury? Yes No If yes, _____ cigarettes per day

Do You Drink Alcohol? Yes No If yes, How much? _____

Do you use recreational drugs? Yes No if yes, describe: _____

Have you used amphetamines? Yes No if yes, When? _____

YES	NO	Do you feel that you have dry mouth?	Sometimes
YES	NO	Do you have hoarseness?	Sometimes
YES	NO	Does the amount of saliva in your mouth seem to be too little?	Sometimes
YES	NO	Do you have any difficulties swallowing?	Sometimes
YES	NO	Does your mouth feel dry when eating a meal?	Sometimes
YES	NO	Do you sip liquids to aid in swallowing dry food?	Sometimes

Patient's Signature: **X** _____ Date: ____ / ____ /202____

HAWTHORNE RESEDA ANAHEIM REDLANDS SACRAMENTO

PRIVATE WCAB QME PQME APQME AME UNREPRESENTED PERSONAL INJURY

Name: _____ M ___ F ___ Date: ____ / ____ /202____ Interpreter: _____

Date of Injury: _____ PTP: DR. _____

Employment History

Employed at: _____ for _____ years months

Job Title: _____

Worked _____ Days per week; Worked _____ Hours per day

Right Left Hand Dominant

What did patient do at the job?

Job Requirements: driving walking standing sitting squatting twisting

bending forward side bending reaching below shoulder level reaching above shoulder level

pushing pulling grasping gripping

lifting up to maximum of _____ lbs. carrying up to maximum _____ lbs.

typing using a computer mouse: R L non-ergonomic: desk chair work station

non-fully adjustable chair with non-adjustable arm rest computer monitor located in: F R L

cradling the phone on: R L writing

Current Work Status: Disabled Still working at the same company Not Working/Retired

Date Stopped working _____

Presently working at different company _____ as _____

Job duties:

Job Requirements: driving walking standing sitting squatting twisting

bending forward side bending reaching below shoulder level reaching above shoulder level

pushing pulling grasping gripping

lifting up to maximum of _____ lbs. carrying up to maximum _____ lbs.

typing using a computer mouse: R L non-ergonomic: desk chair work station

non-fully adjustable chair with non-adjustable arm rest computer monitor located in: F R L

cradling the phone on: R L writing

(If Applicable) Reviewed History of Trauma with patient as per the report of Dr. _____ Date: ____ / ____ / 20____

Patient's Signature: X _____ Date: ____ / ____ / 20____

History of Industrial Injury

(Patient is a Poor Historian: Yes No)

Orthopedic injuries to:	Freq-%	VAS
Neck		
R Shoulder		
L Shoulder		
R Arm		
L Arm		
R Elbow		
L Elbow		
R Wrist		
L Wrist		
R Hand		
L Hand		
R Fingers		
L Fingers		
Upper Back		
Mid Back		
Low Back		
R Hip		
L Hip		
R Leg		
L Leg		
R Knee		
L Knee		
R ankle		
L ankle		
R foot		
L Foot		

1)

2)

3)

CT: repetitive trauma resulting in orthopedic injuries

If MVA Driver Passenger Right Rear Seat Left Rear Seat Vehicle Hit On: R L Front Rear
 Wearing a seatbelt? Yes No Airbag Deployed? Yes No Thrown About? Yes No
 Struck Mouth Face? Steering Wheel Door Window Struck back of head on headrest? Yes No
 Direct Trauma to the Face/Jaw? R L Scars? _____ Fractured Jaw? Yes No
 Fractured Teeth? # _____ Lost Teeth? # _____

Orthopedic pain causing clenching/bracing of facial muscles Yes No

Developed stressors in response to industrial orthopedic injuries Yes No

Stressors at Work Heavy Workload Long or inflexible hours Tight deadlines Lack of Control

Conflicting or uncertain job expectations Lack of support Poor Relationships _____

Clenching/Bracing of facial muscles in response to stress Yes No

Did the bruxism begin after you started having work related pain/stress? Yes No _____ Days after _____ Weeks after

Bruxism	Clenching	Day	Night
	Grinding	Day	Night
	Bracing Facial Musculature	Day	Night
	Bruxism:	_____ % of Time	_____ VAS Intensity

Pre-Existing Conditions

Headaches _____ % of time _____ intensity of Headache on VAS _____

Vertex R L Forehead R L Temple R L Occiput R L Behind Eyes

R L B Facial Pain _____ % of time _____ intensity of Facial Pain on VAS _____

R L B TMJ Pain _____ % of time _____ intensity of TMJ Pain on VAS _____

Bruxism: _____ % of time _____ intensity of Bruxism on VAS _____

If a nightguard was made (year made) _____ Still uses a nightguard? Y N

Reason stopped using nightguard? Does not fit Lost Wore Out Broken

Did you have any prior problems eating hard or chewy food? Yes No

Did you have any prior problems speaking for prolonged periods of time? Yes No

Treatments Received Due to the Industrial Injury

Surgery to:

Neck	R L Shoulder	R L Arm	R L Elbow	R L Wrist	R L Hand	R L Fingers
R L Thumb	Back	R L Hip	R L Knee	R L Leg	R L Feet	R L Ankles

How many times? _____

Tx Received:

Physical Therapy Chiropractic Manipulations Acupuncture Injections: Steroid Spinal Trigger Point

Psychological Therapy: Evaluated by _____

Neurologist: Evaluated by _____

Prior History

Past Medical History: None

Past Surgeries: None

History of Prior Industrial Injuries: None

History of Non-Industrial Injuries: None

MVA _____ Injured _____ No facial/Jaw problems or pain

Residual Problems: None _____

MVA _____ Injured _____ No facial/Jaw problems or pain

Residual Problems: None _____

MVA _____ Injured _____ No facial/Jaw problems or pain

Residual Problems: None _____

MVA _____ Injured _____ No facial/Jaw problems or pain

Residual Problems: None _____

Any Injuries After the Date of Industrial Injury (Industrial or Non-Industrial):

None

Dental History

When was the last time you were seen by a dentist, besides in our office?

Years ago Months ago Weeks ago
 Other Never

When was the last time you had Full Mouth X-Ray taken? _____

To the best of your ability, please list the name(s), addresses and phone numbers of your prior dentist(s):

Dental Treatments: Regular dental checkups/polishing of teeth

Every: 6 months year Last time patient had teeth cleaned _____

Name of Dentist: _____ Phone #: _____

Dental Treatments Received Since Industrial Injuries:

If yes, Name of Dentist: _____ Phone #: _____

Gum Treatments

Restorations on teeth in UR UL LR LL

Root Canals in UR UL LR LL

Crowns in UR UL LR LL

Implants in UR UL LR LL

Upper Lower Partial Denture

Upper Lower Complete Denture

Upper Lower Bruxism Oral Appliance Oral Sleep Appliance

Extractions: Wisdom teeth Teeth # _____

Missing Teeth? _____ Prior to the industrial injury?# _____ After the Injury?# _____

Present Symptoms

Weight Gain Loss _____ lbs Loss due to Facial Pain Diet
 Present Weight _____ Kg Height _____ cm Frame Small Medium Large

Snores	Yes	No	Pre-existing	Aggravated	After Work Injury
Gasps for Air at Night	Yes	No	Pre-existing	Aggravated	After Work Injury
Palpitations on Awakening	Yes	No	Pre-existing	Aggravated	After Work Injury
Breathing Cessation at Night	Yes	No	Pre-existing	Aggravated	After Work Injury
Patient had Sleep Study	Yes	No			

If yes for sleep study: Date of study _____, Patient diagnosed with a Sleep Disorder _____ Patient does not know results,
 Given mask during Sleep Study Used CPAP during Sleep Study Patient given CPAP

Patient uses CPAP _____ times per week at night for _____ hours, Patient cannot tolerate CPAP. X _____

Headaches	On Top of Head	Temple	Forehead	Occipital	Behind the Eyes
	R	L	R	L	
	Occasional, Intermittent, Frequent, Constant,			Dull, Aching, Burning, Stabbing, Electrical,	
	Minimal, Slight, Moderate, Severe			Sharp, Shooting, Numbness, Pins, Needles, Pulsing	
	_____ % of Time	_____ VAS		Started Approx.: _____	

Do you think your bruxism may have caused you to have headaches? Yes No

Right Face Pain	Occasional, Intermittent, Frequent, Constant,	Dull, Aching, Burning, Stabbing, Electrical,
	Minimal, Slight, Moderate, Severe	Sharp, Shooting, Numbness, Pins, Needles, Pulsing
	_____ % of Time	_____ VAS

Left Face Pain	Occasional, Intermittent, Frequent, Constant,	Dull, Aching, Burning, Stabbing, Electrical,
	Minimal, Slight, Moderate, Severe	Sharp, Shooting, Numbness, Pins, Needles, Pulsing
	_____ % of Time	_____ VAS
		Started Approx.: _____

Do you think your bruxism may have caused you to have face pain? Yes No

Noises in TMJ	R L Grinding, Clicking	Started Approx.: _____
		If applicable, Pre-Injury / TMJ Noise VAS _____ Post Injury / TMJ Noise VAS _____

Right TMJ Pain	Occasional, Intermittent, Frequent, Constant,	Dull, Aching, Burning, Stabbing, Electrical,
	Minimal, Slight, Moderate, Severe	Sharp, Shooting, Numbness, Pins, Needles, Pulsing
	_____ % of Time	_____ VAS

Left TMJ Pain	Occasional, Intermittent, Frequent, Constant,	Dull, Aching, Burning, Stabbing, Electrical,
	Minimal, Slight, Moderate, Severe	Sharp, Shooting, Numbness, Pins, Needles, Pulsing
	_____ % of Time	_____ VAS
		Started Approx.: _____

Limited Opening of the Mouth Yes No

Locking Yes No Closed _____ X per day wk month Open _____ X per day wk month

First locked _____

* *Can self-manipulate Jaw to unlock?* Yes No

Difficult and painful to chew hard food: Face TMJ Teeth
R L R L

Bite feels off Yes No

Facial Pain Smiling Yawning

Soreness of teeth upon waking up in the morning? Yes No

Soreness in Face/Jaw Upon Awakening? Yes No R L

Teeth are sensitive to hot and cold? Yes No

Bleeding Gums? Yes No

* **Speech Dysfunction** Indistinct Articulation, Hoarseness, "Cotton Mouth", Missing Upper Anterior Teeth,
Cannot Talk for Long Periods of Time Due to Pain Jaw Tiredness Can Speak Max. Time _____ Minutes,
Voice Changes In: Tone Pitch Slurring Drooling People Asking Patient To Repeat Themselves

Ear Problems R L Both Ringing Pain Pressure Loss of Hearing Itching Buzzing Static

Sleep Disturbances Yes No

Fatigue Yes No

Generalized tenderness all over the body? Yes No

Stress Increases Pain? Yes No

Prior Injuries to Face / Jaw Yes No

Activities of Daily Living

Self-Care Hygiene

- | | |
|--------------------|---|
| Brushing Teeth | <ul style="list-style-type: none">• None Mild Moderate Severe• Due to pain in facial musculature |
| Compromised | <ul style="list-style-type: none">• Due to limited opening of the mouth• Due to shoulder, arm, elbow, wrist, hand, fingers injury• Due to lack of motivation, lack of concentration, and/or forgetfulness caused by stressors |

- Flossing Teeth**

 - None Mild Moderate Severe
 - Due to pain in facial musculature
 - Due to limited opening of the mouth
 - Due to shoulder, arm, elbow, wrist, hand, fingers injury
 - Due to lack of motivation, lack of concentration, and/or forgetfulness caused by stressors

Compromised

Communication

Motor Function

- | | |
|-------------|--|
| Mastication | <ul style="list-style-type: none"> • None Mild Moderate Severe • Due to pain in facial musculature • Due to pain in teeth • Due to dryness of the mouth |
| Tasting | <ul style="list-style-type: none"> • None Mild Moderate Severe • Due to dryness of the mouth causing a change in taste: Bitter Metallic Bland |
| Swallowing | <ul style="list-style-type: none"> • None Mild Moderate Severe • Due to dryness of the mouth |

Bruxism

- None Mild Moderate Severe
 - In response to pain • In response to resultant stress
 - May be due to side effect of anti-depressant medications taken on an industrial basis
 - Had Sleep Study, and may be contributed to by nocturnal obstructions of the airway

Sexual Function

- Kissing, Oral Activities

 - None Mild Moderate Severe
 - Due to pain in facial musculature
 - Due to Halitosis

Clinical Examination

Unspecified Rheumat.	Yes	No	Tender Phalanges	R	L	Multiple Tender Points	Sleep Disturbances	Fatigue
Facial Palsy	Right	Left						
Facial Atrophy	Right	Left						
Facial Hypertrophy	Right	Left						
Dyskinesia	Yes	No						
Tongue Protrusion	Right	Left	Straight					

Range of Motion:

Maximum Interincisal Opening _____ mm Pain: R L Face TMJ _____ VAS

Right Lateral _____ mm Pain: R L Face TMJ _____ VAS

Left Lateral _____ mm Pain: R L Face TMJ _____ VAS

Protrusion _____ mm Pain: R L Face TMJ _____ VAS

Jaw Deviation Deflection Opening Closing R L _____ mm **S-Form Deviation** R L

Capsulitis	Yes	No	Right Lateral Pole	Pain: _____ VAS	Left Lateral Pole	Pain: _____ VAS
			Right VIA EAM	Pain: _____ VAS	Left VIA EAM	Pain: _____ VAS

Joint Noises (Manual) Right Left Crepitus Clicking Translational Lateral

		Tenderness:		Palpable Taut Bands / Trigger Points:		WRP To:					
Temporalis	R	_____ VAS	Y	N	RPTHA	Face	Temple	Forehead	Eye	Teeth	
	L	_____ VAS	Y	N	RPTHA	Face	Temple	Forehead	Eye	Teeth	
Masseter	R	_____ VAS	Y	N	RPFP	Face	Temple	Forehead	Eye	Teeth	
	L	_____ VAS	Y	N	RPFP	Face	Temple	Forehead	Eye	Teeth	
Occipitals	R	_____ VAS			RPOHA	Face	Temple	Forehead	Eye	Top	
	L	_____ VAS			RPOHA	Face	Temple	Forehead	Eye	Top	
Trapezius	R	_____ VAS	Y	N		Face	Temple	Forehead	Eye	Neck	Occiput
	L	_____ VAS	Y	N		Face	Temple	Forehead	Eye	Neck	Occiput
SCM	R	_____ VAS	Y	N		Face	Temple	Forehead	Eye		
	L	_____ VAS	Y	N		Face	Temple	Forehead	Eye		
Lat. Pterygoid	R	_____ VAS	Y	N		Face	Temple	Forehead	Eye	Neck	
	L	_____ VAS	Y	N		Face	Temple	Forehead	Eye	Neck	

Class I II III Overbite _____ mm Overjet _____ mm Midline Deviation _____ mm R L

Crossbite Ant. R L Closed Bite Collapsed Bite Unstable Bite

Open Bite Ant. R L

Tongue Thrust Ant. R L Both Sides Tori Max Man

Scalloping Right Left Minimal Slight Moderate Significant

Buccal Mucosal Ridging Right Left Minimal Slight Moderate Significant

Occlusal Wear None Apparent Right Left Ant. Minimal Slight Moderate Significant

Patient Has: FUD FLD UPD LPD

Fractured Dentures Upper Lower Full Partial

Abfractions on Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Missing Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Missing Third Molars # 1 16 17 32

Gum Recession Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Fractured Teeth # _____

Fractured Bridge or Crowns # _____

Visually Apparent Decayed Teeth # _____

Broken Dental Filling # _____

Teeth Sensitive to Percussion # _____

Teeth sensitive to Periapical Palpation # _____

Teeth with Mobility # _____

Bleeding Gums Yes No

Inflamed Gingiva Yes No

Scars? Detail: _____

Malampati: _____ Friedman: _____

Diagnostic Tests

Blood Pressure _____ / _____

Ultrasound Doppler Analysis

Click

Opening R _____ L _____ RRL _____ RLL _____

Closing R _____ L _____ LRL _____ LLL _____

No Clicking was Auscultated _____

Damage

Translation R _____ L _____ Lateral R _____ L _____

Muscle Temperature in C°

R Temporalis _____ L Temporalis _____

R Masseter _____ L Masseter _____

R SCM _____ L SCM _____

R Trapezius _____ L Trapezius _____

Diagnostic Bite Force Analysis /

Musculoskeletal Functional Capacity

Right _____ Newtons Left _____ Newtons

EMG Results

Right Masseter

_____ μV Rest
_____ μV Contraction
_____ μV Peak

Left Masseter

_____ μV Rest
_____ μV Contraction
_____ μV Peak

Right Temporalis

_____ μV Rest
_____ μV Contraction
_____ μV Peak

Left Temporalis

_____ μV Rest
_____ μV Contraction
_____ μV Peak

Elevated Muscular Activity

Yes No

Incoordination/Aberrant Function

Yes No

Diagnostic Autonomic Nervous System

Before: O₂ _____ Pulse _____

After: O₂ _____ Pulse _____

Amylase Test _____

Salivary Diagnostic Testing

Visual Evaluation

Tissue Analysis of Lips Dry Cracked Wet

Tissue Analysis of Tongue Fissuring Dry White Patches

Quality of Saliva Cloudy Ropey Viscous Bloody

Saliva Pooling at Floor of Mouth Yes No

Adherence of Tongue Depressor on inside of cheek Yes No

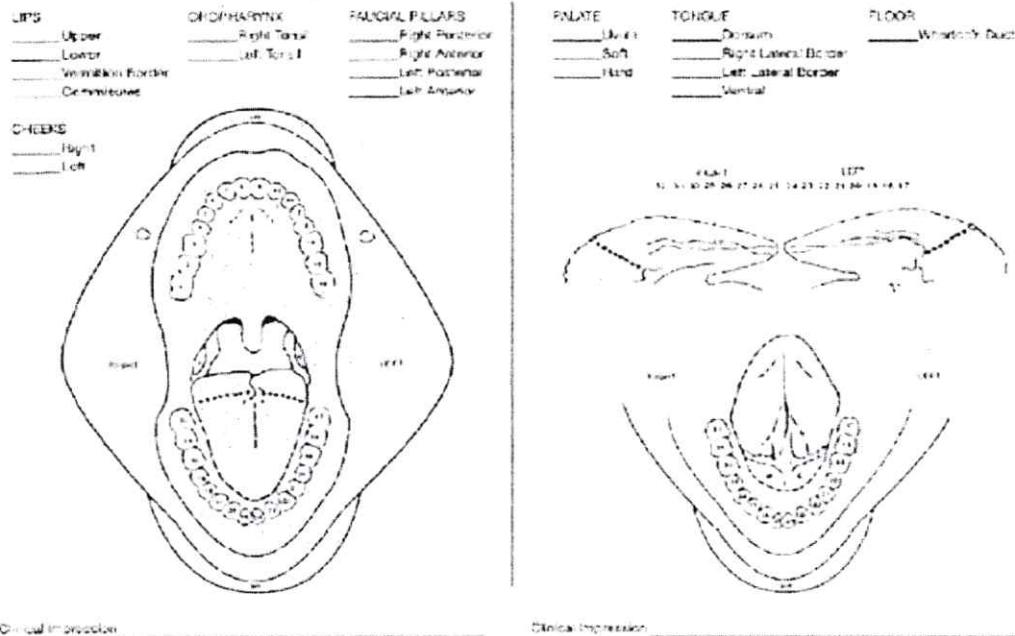
Salivary Flow Unstimulated Less than 0.1mL Greater than 0.1mL

Stimulated Less than 0.5mL Greater than 0.5mL

Salivary pH Analysis _____

Gingival Bleeding Yes No

Oral Cancer Screening Form



Clinical Impression _____

DFV

Diagnosis

- S09.93XA Traumatic Injury to Face Mandible Teeth # _____
- G51.0 Facial Palsy Right Left
- G50.0 Trigeminal Nerve Neuropathic Pain / Central Sensitization
- F45.8 Bruxism
- M79.1 Myalgia of Facial Muscles
- M65.80 Capsulitis / Inflammation Right Left
- M26.69 Internal Derangement Right Left
- M26.69 Osteoarthritis Right Left
- M26.69 Osteoarthritis Right Left
- K05.6 Inflammation of the Gums
- R19.6 Suggestions of an Unspecified Rheumatological / Systemic Condition
- G51.0 Halitosis / Oral Malodor

Other: _____

Trigeminal Nerve Neuropathic QST Testing

QST

Right Forearm	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Right Temporalis	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Right TMJ	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Right Masseter	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left Temporalis	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left TMJ	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left Masseter	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
_____	_____ VAS	_____ Seconds	Sharp	Electrical	Burning

QST Cold

Right Temporalis	_____ VAS	Sharp	Electrical	Burning
Right TMJ	_____ VAS	Sharp	Electrical	Burning
Right Masseter	_____ VAS	Sharp	Electrical	Burning
Left Temporalis	_____ VAS	Sharp	Electrical	Burning
Left TMJ	_____ VAS	Sharp	Electrical	Burning
Left Masseter	_____ VAS	Sharp	Electrical	Burning
_____	_____ VAS	Sharp	Electrical	Burning

QST After Bilateral SPGB, if necessary

Right Temporalis	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Right TMJ	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Right Masseter	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left Temporalis	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left TMJ	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
Left Masseter	_____ VAS	_____ Seconds	Sharp	Electrical	Burning
_____	_____ VAS	_____ Seconds	Sharp	Electrical	Burning

Diagnostic Photographs

Lateral Border of the Tongue Scalloping

Buccal Mucosal Ridging Right Left

Occlusal Wear Anterior Generalized

Bleeding on Flossing

Tongue Blades adhering to inside of cheeks

Erosion Class I II III Occlusion

Abfractions

Cervical Decay

Generalized Decay

Biofilm on Teeth

Biofilm on Gums

Swollen Gums

Gum Recession

Maxillary Torus

Mandibular Tori

Deviation of Tongue on Protrusion Right Left

Deviation of Mandible Upon Opening Right Left

Facial Palsy Right Left

Broken Porcelain on Bridge

Broken Denture

Missing Broken Teeth #: _____

Open Bite Anterior Right Left

Cross Bite Anterior Right Left

Collapsed Bite Unstable Bite Off Bite

Facial Scarring

Hypertrophy of Masseter Muscle Right Left Bilateral

Tongue Trust Anterior Lateral Right Left

Treatment Plan

- Orthotic Appliance / Resilient Orthotic OAOA OSA TRD Diagnostic Splint
- Craniofacial Exercises
- Trigger Point Injections
- Sphenopalatine Ganglion Blocks
- Trigeminal Pharyngoplasty
- FMX
- Panorex
- MRI if locking Persists
- Surgical Consultation if Locking Persists

- Sleep Study Report Needed
- Polysomnogram Needed
- Physical Therapy Treatment Needed
- Psychological Consultation Needed
- Neurological Care Needed
- Orthopedic Consultation Needed
- Rheumatological Consultation to rule out Fibromyalgia Needed
- Plastic Surgery Consultation Needed for _____
- ENT Consultation Needed for: Ringing in ears Hearing Loss _____
- Internal Medicine Consult Needed for: HBP Diabetes GERD Kidney Thyroid _____

- Referral for Evaluation And Treatment with Prosthodontic/Periodontist Specialist
- Oral Surgery Consultation
- Orthodontic Consultation
- Dental Consultation for: Treatment for Decay Fractured Teeth Xerostomia / Periodontal Disease

- Patient to get Dental Records / FMX
- Patient to get Prescriptions from Pharmacy
- I NEED ALL MEDICAL AND DENTAL RECORDS

- Patient informed they must see any dentist for X-rays to determine if any fracture, decay, and / or periodontal disease is present that can be caused or aggravated by their industrially related xerostomia or bruxism conditions.
- Patient informed they must see any dentist for the decay and / or periodontal disease that can be caused or aggravated by their industrially related xerostomia.
- Patient informed that if they require dental treatment for decay or fractured teeth that was caused or aggravated by their industrially related xerostomia, or trauma, or bruxism, that no treatment will be performed by our office for the decay or fractured teeth until authorization and payment is made to our office by the workers compensation insurance company; and therefore they must seek the required treatment at any dental office to be paid for by the patient them self.

Dr. Signature: **X** _____ Date: _____ / _____ /202 _____

Informed Consent

It has been fully explained to me, and I understand, that the diagnosis and treatment of problems in the areas of facial pains, headaches, TMJ problems, and Sleep Breathing Disorders are extremely complex, where there can be many contributing medical factors that cause these problems and complaints which I am experiencing. I, therefore, understand that the doctor's diagnosis of my problems is only a preliminary diagnosis based on the available information, examination, and testing.

It has been fully explained to me and I understand that the treatments which the doctor recommends are diagnostic treatments, where my diagnosis and future treatments may change based upon my outcome. Results of treatment are never guaranteed as my findings and symptoms may be due to multiple causes.

It has been fully explained to me and I understand, that I may require referral to other medical and/or dental specialists or outside testing such as an MRI, etc., and that I solely am responsible for any such outside testing and other physician/dental consultations.

It has been fully explained to me and I understand, that I have developed stress in response to my pain, and that this stress as well as any pre-existing stress or social factors may be contributing to my pain and symptoms. I understand that I, therefore, require psychiatric/psychological therapy to help me manage my stress. I understand that the doctor is recommending that I have these psychiatric/psychological evaluations and any necessary therapy in order to assist in alleviating and/or managing my pain and symptoms. I solely am responsible for any such outside consultations, testing, and treatments.

It has been fully explained to me and I understand that I may require medications to treat and relieve my pain and symptoms, and that the doctor recommends that all required medications be prescribed by my Primary Treating Medical Physician or other medical physician specialists.

It has been fully explained to me and I understand that no guarantees as to the success of my treatments can be given.

I fully understand that I always have the option to refuse the treatment recommendations by the doctor. I am not being forced to, and I do not have to choose any of the treatments provided for me by the doctor. I do so by my own volition and decision.

I do hereby consent to and authorize the performance of all diagnostic tests, laboratory procedures, the performance of any and all medical procedures and treatments that may be necessary or advisable by the dentist and his staff for my objectively documented findings. I authorize and consent that the doctor chooses and employs such assistance as they deem necessary. I understand there are possible and real risks. All of my questions have been

answered to my satisfaction. Initials X _____

Page 1 of 2 Pages

I attest that to the best of my present knowledge and recall, that all that I have told the doctor and his office is true, and that I did not have any previous permanent disabilities or physical impairments except for the pre-existing problems which I have reported to them.

I have been informed and fully understand that I have gum disease and/or dental decay and/or active abscesses and infections of my teeth and gums. I have been informed and fully understand that I am personally responsible to have my gums and teeth treated by my personal dentist, and that I am being seen for my work injury and thus these types of treatments cannot be performed by Dr. Schames' office unless the treatments are authorized by the worker's comp insurance company.

I have been informed and fully understand that wearing an oral appliance can cause changes in my bite and the way my teeth will come together, and/or pain in my face and jaw joints, and/or changes and noises in my jaw joints. I fully understand that these are possible and real complications, and I still accept these treatments.

I have been informed and fully understand that I must immediately follow any of the doctor's instructions or referrals to other specialists. Additionally, I have been informed and fully understand that I must immediately return and inform the doctor of any changes or problems with my treatment or condition.

I acknowledge that the benefits, risks, and alternatives have been discussed with me including improvement of symptoms, worsening of symptoms, and/or no change in symptoms, and my questions were answered to my satisfaction.

I hereby choose to proceed with the treatments as recommended by the doctor and his staff.

I acknowledge that I have received a copy of this informed consent.

SIG:X _____ Date: ____ / ____ / 2025

Witness: _____

MAX OPENING BEFORE TREATMENT _____

MAX OPENING AFTER TREATMENT _____

<input type="checkbox"/> INITIAL CONSULTATION
<input type="checkbox"/> OFFICE VISIT
<input type="checkbox"/> COMP. RE-EVALUATION
<input type="checkbox"/> INTERMEDIATE/OV EXPAND
<input type="checkbox"/> DISCHARGE EXAMINATION
T.H.

PHYSICAL MEDICINE MODALITIES		CPT
<input type="checkbox"/> DIAGNOSTIC ORTHOTIC	<input type="checkbox"/> TRD	
<input type="checkbox"/> ORTHOTIC TRAINING		
<input type="checkbox"/> ORTHOPEDIC ORTHOTIC	X	
<input type="checkbox"/> MAN	<input type="checkbox"/> MAX	
<input type="checkbox"/> 2MM	<input type="checkbox"/> 3MM	
<input type="checkbox"/> ORTHOPEDIC ORTHOTIC	<input type="checkbox"/> DAY	<input type="checkbox"/> NIGHT (OSA)
<input type="checkbox"/> ORTHOTIC ADJUSTMENT / RELINE		
OAO / OSA ADJUSTMENT / RELINE		
ADDITIONAL		
<input type="checkbox"/> DIAGNOSTIC PHOTOGRAPHS		
<input type="checkbox"/> FULL MOUTH RADIOGRAPHS		
<input type="checkbox"/> ORTHOPANTOMGRAM		
<input type="checkbox"/> SINGLE PA		
<input type="checkbox"/> PHOTO BIO-MODULATION	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT
RX: <input type="checkbox"/> XEROSTOMIA MEDICATION		
REFER FOR:		
<input type="checkbox"/> PATIENT WILL BRING IN XRAYS FOR REVIEW		
<input type="checkbox"/> DENTAL TX W/ PROSTHODONTIST / PERIODONTIST	<input type="checkbox"/> FOR TEETH	
<input type="checkbox"/> MRI	<input type="checkbox"/> CT SCAN	<input type="checkbox"/> FMX/ PANOREX
<input type="checkbox"/> QUAD, SGRP-PROPHY-FLUORIDE/OHI		
<input type="checkbox"/> % S.I. IN FACE/JAW AFTER TPI'S		

DIAGNOSTIC AUTONOMIC NERVOUS SYSTEM TESTING

 RIGHT SPGB LEFT SPGB DMR B/P: _____ / _____

T.P. INJECTIONS

____ CC OF 1.0% XYLOCAINE

MUSCLE	TWITCH RESPONSE	REFERRED PAIN TO:	PAIN
<input type="checkbox"/> Trapezius / Right	_____	_____	_____
<input type="checkbox"/> Trapezius / Left	_____	_____	_____
<input type="checkbox"/> Suboccipital / Right	_____	_____	_____
<input type="checkbox"/> Suboccipital / Left	_____	_____	_____
<input type="checkbox"/> SCM / Right	_____	_____	_____
<input type="checkbox"/> SCM / Left	_____	_____	_____
<input type="checkbox"/> Masseter / Right	_____	_____	_____
<input type="checkbox"/> Masseter / Left	_____	_____	_____
<input type="checkbox"/> Temporalis / Right	_____	_____	_____
<input type="checkbox"/> Temporalis / Left	_____	_____	_____

 The Patient has elevated Blood Pressure I have informed the patient that they need to see their M.D. for elevated Blood Pressure.

Note: _____

NEXT VISIT FOR: DEL 2MM DEL 3MM TPI'S SPGB OAOA OSA P/S

DOCTOR'S SIGNATURE: _____ TODAY'S DATE: _____

NEXT VISIT DATE: _____