Dr Henry T Young 415- 73rd Street Brooklyn, NY 11209 718-238-7878

Orofacial Pain and Temporomandibular Disorders
Fellow American Board of Orofacial Pain
Clinical Assistant Professor NYU College of Dentistry
General Dentist

WELCOME

In order to expedite your visit, please fill out the enclosed history sheets as completely as possible, and bring them with you for your appointment. If the question does not apply to you, write "n/a" (not applicable) or if you are not sure of an answer, write "not sure". Do not leave any answers blank. Giving us a thorough history will allow us to help you better.

We recommend that a copy of our findings and treatment recommendations be sent to your physician, general dentist, and any practitioners you have consulted for this problem. The state of New York requires that we obtain a signed release from patients before we are allowed to release records. Enclosed, you will find a release form; please write the name and address of each person you want a report sent to.

Please feel free to call if you have any questions.

Dr Henry Young and Staff.

Dr Henry T Young 415 - 73rd Street Brooklyn, NY 11209 718-238-7878
General and Cosmetic Dentistry
Orofacial Pain and Temporomandibular Disorders
Diplomate American Board of Orofacial Pain
Fellow American Academy of Orofacial Pain
Fellow Academy of General Dentistry

We would like to welcome you to our office. To avoid confusion and misunderstandings, we would like to inform you of our office payment policy.

Payment for services rendered is due at the time of treatment. We accept cash, Mastercard/Visa, and money orders. We do not accept personal checks for the first visit.

We do not accept insurance as payment. We are not a participating dentist in any insurance plans. We do however, as a courtesy for our patients, fill out the insurance forms and submit them for payment to the patient. In other words, the patient will pay us at the time of service, and their insurance will reimburse them directly for covered services.

Please note that we do not participate with Medicaid, Medicare, nor No-fault insurance. You will not be able to submit claims for services performed.

Please arrive on time for your appointment so that we can spend the appropriate amount of time with you, without rushing through the treatment. We try very hard to stay on schedule so our patients do not have to wait. However, please understand that occasionally procedures take longer than anticipated, and there may be a short wait.

If you will be arriving by car, you should be aware that parking in this area can be difficult at times, and extra time is usually needed to find parking.

Please fill out the enclosed medical history and bring it with you for your appointment. Do not leave any answers blank; write “N/A” if not applicable, or “not sure” if you do not know the answer.

Again, welcome to our office; we look forward to meeting you and providing you with our service. If at any time you have any questions, please feel free to call us.

Your appointment is for _____

This time is reserved exclusively for you. 24 hours notice is required if you are unable to keep your appointment.

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NAME_____ Date_____

Whom may we thank for referring you here?_____

Family Physician_____
Address_____
City, State_____Zip_____
Phone( )_____

On the lines below, please list the doctors you have consulted for your complaint. Briefly describe their diagnosis, treatment and results. Be certain to include medications prescribed for you. Please bring copies of all available reports, x-rays, and MRIs.

Dr._____Phone( )_____
Address_____
City, State_____Zip_____
Specialty_____Date Seen_____
Diagnosis and Treatment_____

Dr._____Phone( )_____
Address_____
City, State_____Zip_____
Specialty_____Date Seen_____
Diagnosis and Treatment_____

Dr._____Phone( )_____
Address_____
City, State_____Zip_____
Specialty_____Date Seen_____
Diagnosis and Treatment_____

Dr._____Phone( )_____
Address_____
City, State_____Zip_____
Specialty_____Date Seen_____
Diagnosis and Treatment_____

Please use the back if additional space is needed.

Name_____ Date_____

Please write a brief description of your problem(s); for example – jaw pain left side; pain in left ear; headache; neckache; tooth pain; etc. Write the problem that bothers you the most first, then the next most bothersome problem and so on. Use a separate line for each problem (use the back of the page if more room is needed).

For problems related to pain, rate the pain from 0 (0= no pain) to 10 (10= your worst pain).

Problem #1._____

How long have you the problem?_____

Severity of pain: 0----1----2----3----4----5----6----7----8----9----10

-How often has it happened this past week? _ once; _ every day; _ 2+ times every day; _ constant; _varies.
-How long does it usually last? _ Less than 1 minute; _ 1 to 10 minutes; _ hours; _ days; __ has been constant; _ varies.

-What makes it worse?_____

-What makes it better?_____

-Does it feel sharp, dull, burning, tingling, throbbing? Circle all that apply.

* * * * * * * * * * * *

Problem #2._____

How long have you the problem?_____

Severity of pain: 0----1----2----3----4----5----6----7----8----9----10

-How often has it happened this past week? _ once; _ every day; _ 2+ times every day; _ constant; _varies.
-How long does it usually last? _ Less than 1 minute; _ 1 to 10 minutes; _ hours; _ days; __ has been constant; _ varies.

-What makes it worse?_____

-What makes it better?_____

-Does it feel sharp, dull, burning, tingling, throbbing? Circle all that apply.
* * * * * * * * * * * *

Problem #3._____

How long have you the problem?_____

Severity of pain: 0----1----2----3----4----5----6----7----8----9----10

-How often has it happened this <u>past week</u>? _ once; _ every day; _ 2+ times every day; _ constant; _varies.
-How long does it usually last? _ Less than 1 minute; _ 1 to 10 minutes; _ hours; _ days; __ has been constant; _ varies.

-What makes it worse?_____

-What makes it better?_____

-Does it feel sharp, dull, burning, tingling, throbbing? Circle all that apply.

* * * * * * * * * * * *

Problem #4._____

How long have you the problem?_____

Severity of pain: 0----1----2----3----4----5----6----7----8----9----10

-How often has it happened this <u>past week</u>? _ once; _ every day; _ 2+ times every day; _ constant; _varies.
-How long does it usually last? _ Less than 1 minute; _ 1 to 10 minutes; _ hours; _ days; __ has been constant; _ varies.

-What makes it worse?_____

-What makes it better?_____

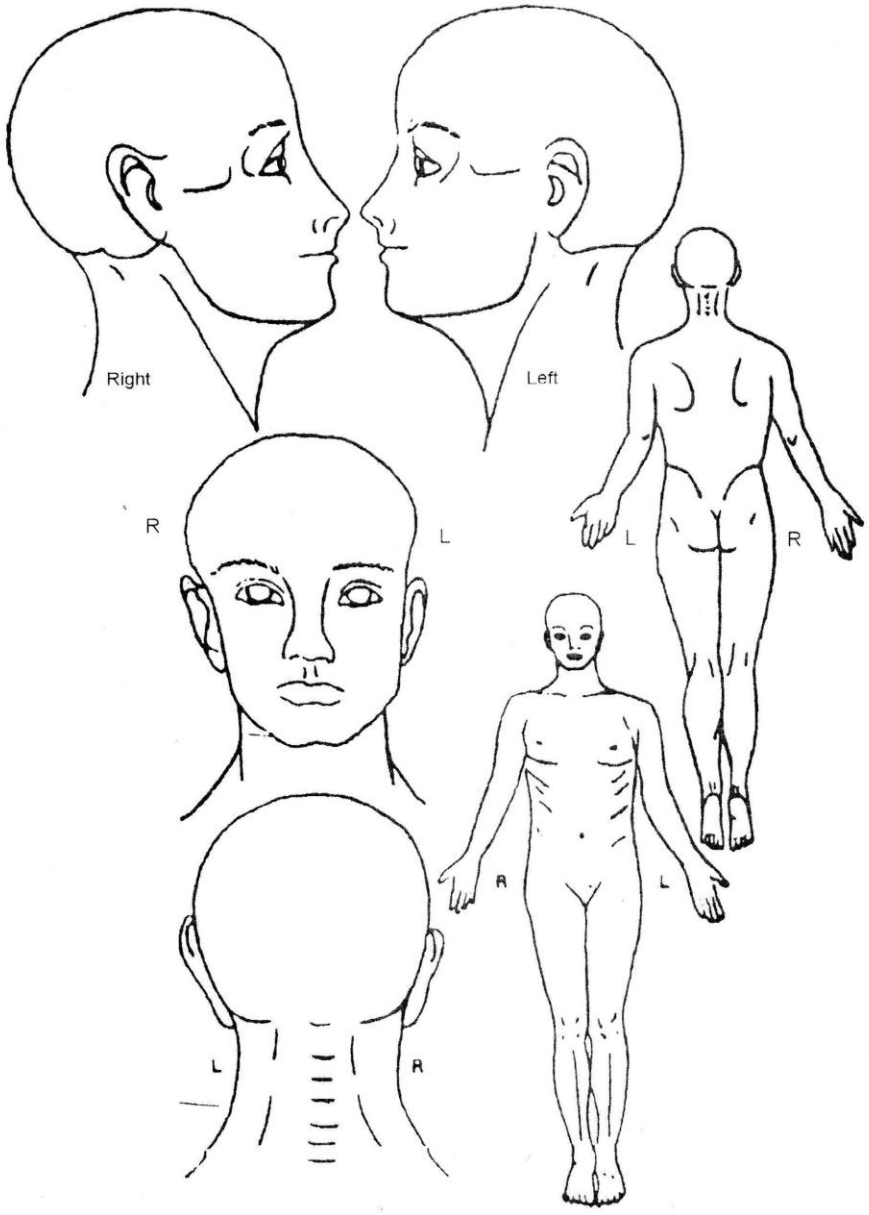
-Does it feel sharp, dull, burning, tingling, throbbing? Circle all that apply.

* * * * * * * * * * * *

Mark the areas of pain with an “X”

AMERICAN ACADEMY OF OROFACIAL PAIN **SPECIFIC AREAS OF PAIN**

Please mark the area(s) of pain on the diagram



NAME_____ Date_____

DO YOU:	YES	NO
Have a stressful situation at work?	( )	( )
Have a stressful situation at home?	( )	( )
Have a decreased appetite?	( )	( )
Feel low in energy or slowed down?	( )	( )
Feel easily annoyed or irritated?	( )	( )
Consider yourself to be a perfectionist?	( )	( )
Feel little interest in doing things?	( )	( )
Feel lonely even with people ?	( )	( )
Feel hopeless about the future?	( )	( )
Have a decreased desire for social activities?	( )	( )
Have a loss of sexual interest or pleasure?	( )	( )
Have thoughts of suicide?	( )	( )
See or have seen a psychiatrist, psychologist, or social worker	( )	( )

If yes, please explain: _____

SLEEPING HABITS:

Do you:	YES	NO
Wake up in the morning with a headache?	( )	( )
Sleep well at night?	( )	( )
Have trouble falling asleep?	( )	( )
Take medication or alcohol to fall asleep?	( )	( )
Wake up frequently during the night?	( )	( )
Snore while sleeping?	( )	( )
Clench your teeth at night?	( )	( )
Thrash your legs in your sleep?	( )	( )
Feel exhausted upon arising?	( )	( )
Feel rested upon awakening?	( )	( )
Have stiff muscles in the morning?	( )	( )
Have difficulty staying awake during the day?	( )	( )
Feel tired during the day?	( )	( )

Pain issues can be related to sleep disorders. Please complete this questionnaire:

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician/dentist.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	

I, _____, hereby authorize

Dr. Henry Young to release all my records and x-rays to:

_____ _____

Signature of patient or guardian date