Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Chief Complaint / Diagnosis: _____

_____

- ○ Evaluate and Treat
- ○ Specific Procedure Requests: _____

_____

_____

Please Evaluate:

- ○ Ear Pain
- ○ Facial Pain
- ○ TMJ Pain
- ○ Tooth Pain
- ○ Mouth Pain
- ○ Headache
- ○ TMJ Popping or Clicking
- ○ Burning Tongue
- ○ Movement Disorder
- ○ Locked Jaw

Patient Has:

- ○ Had TMJ Surgery
- ○ Had Full Dental Reconstruction
- ○ Nightguard or Splint
- ○ Had Jaw or Facial Surgery

Referring Physician or Dentist: _____

Phone: _____ Date: _____

Patient has tried QuickSplint® anterior bite plane with:

Good Results: _____

Mixed Results: _____

No Improvement: _____

Discontinued Use: _____

Signs of Bruxism: _____