John R. Droter, D.D.S.
4000 Mitchellville Rd., B 330
Bowie, Maryland, 20716
301-805-9400
drdroter@mac.com

Thank you for contacting our office. Enclosed are the forms you will need to complete so we may determine the best starting point in helping you with the problem that you have.

1. Facial Problem Questionnaire- 6pages
   Please take your time and fill it out completely. This information is very valuable in determining what is causing the problem. Please sign page 6.
2. Trauma Questionnaire- 2 pages
   Fill out only if you have had a car accident or other trauma to the jaw. If more than one trauma, please fill out a separate one for each accident. Please sign page 2
3. Sleep Fatigue Questionnaire - 4 pages
   Please fill out and sign
4. Medical History- 1 page
   Please fill out and sign
5. Patient Information- 1 page
   Please fill out and sign
6. TMJ Brochure- Information for you about the TMJ
7. Fee/ Insurance Information
8. Medicare Private Contract- Needs to be filled out and signed for all. If below age 18, have parent sign. This is to make sure you are aware that Dr. Droter is not a provider with Medicare.
9. HIPPA Disclosure: Disclosure on the privacy of your health information. Please sign.
10. Directions to our office

Please return the originals by mail (no faxes please) to our office. Dr. Droter will review them and decide what is the next step in helping you. We look forward to meeting you. If you have any additional questions or concerns please do not hesitate to contact me.

Amanda
Patient Care Coordinator

Facial Problem Questionnaire

John R. Droter, D.D.S.
4000 Mitchellville Rd., B330
Bowie, Maryland, 20716

301-805-9400
drdroter@mac.com

Name _____Age_____

Date _____ Referred by _____

Referring Dr.'s Phone # and Email: _____

Please do not write in this space.

Date _____

1. Which of the following do you have (circle all that apply)

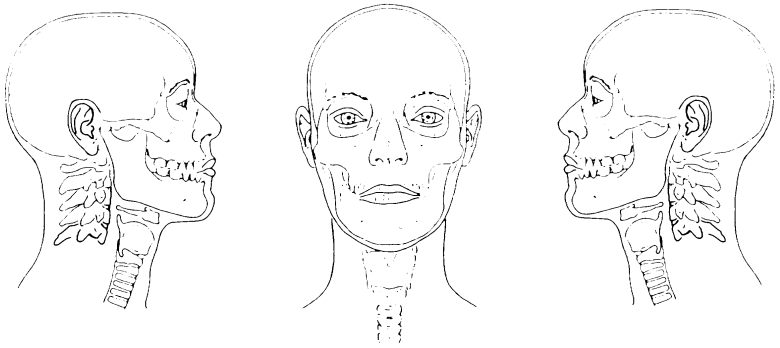
   Headaches Neck Pain Jaw pain Ear Pain

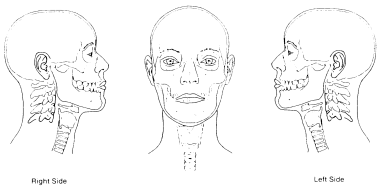
   Facial Pain Bite Problems Damaged teeth Sleep Problem

   Other _____

2. How many days a month are you pain free? _____

   If pain free, go to next page.
   If Pain, Please shade in where your pain is located:





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How long have you had this pain? _____

Is the pain constant? _____

Is the pain (circle all that apply) Aching Burning

Stabbing Sharp Dull Other _____

Is the pain worse in the (circle all that apply)

Morning Afternoon Evening Night

What makes the pain better? _____

_____

What makes the pain worse? _____

_____

How severe is your pain? Please make a mark along the line below:

No Pain |——————————————————————————| Worst Pain Ever

What medication do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

		Yes		No
3.	Any discomfort when you chew?	Y		N
	Which side do you favor chewing on ?	R	L	Use Both
	Is it difficult or painful to swallow?	Y		N
	Any discomfort when you move your jaw?	Y		N
	Any discomfort upon chewing hard foods like carrots?	Y		N
	Do your jaw muscles get tired from chewing?	Y		N
	Does it hurt to open wide?	Y		N
	Which side of your jaw makes a clicking/popping noise?	R	L	neither
	Which side of your jaw makes other noises?	R	L	neither
	What Noises? _____			
	When did you first notice the noises or clicking? _____			
	Have you noticed any changes in noises or clicking?	Y		N
	Explain: _____			
4.	Have you ever not been able to open your jaw all the way?	Y		N
	Have you ever had to wiggle your jaw to get it open?	Y		N
	Has your jaw ever been stuck open and you could not close it?	Y		N
	When did this first happen? _____ Last happen? _____			
5.	Has your speech changed?	Y		N
	Have you noticed a change in the way your teeth come together?	Y		N
	Have you noticed your teeth shifting?	Y		N
	Has the shape of your face changed?	Y		N
	Has your chin shifted to one side of your face?	Y		N
	When did you notice any of the above changes?_____			
6.	Do you have a hyper-sensitive bite?	Y		N
	Is your bite uncomfortable?	Y		N
	When you close your jaw, do you have to search for a comfortable position for your teeth to fit?	Y		N

Please do not write in this space

Chew
Swallow
Speak
Open/Close

Healthy
Damaged
Active breakdown
Adapting
Adapted

Favorable
Unfavorable

TMJ Move

Structurally Stable

Mech Stable

Occl

7. Are your teeth sore or sensitive? Y N

Do you clench your teeth? Y N

Do you grind your teeth? Y N

Do you grind or clench during the day or night? Day Night Both Neither

When did you start clenching or grinding? _____

Please do not write in this space

Parafunction

8. Do you have a dentist who you see for routine care and cleanings? Y N

Please list : _____ Last Visit: _____

PDHx

Which of the following dental procedures have you had (please circle):

Fillings Orthodontics Root Canal Dentures

Crowns Bridges Bite Adjustment

Ortho

If you had braces, how many times were you in braces? _____

How old were you when you got braces? _____

How old were you when you were done? _____

Have you ever had a tooth extracted? Y N

Have you ever split or broken a tooth? Y N

Do you feel there is any connection between the dental work you have had done and the problems you are having? Y N

Trauma

9. Have you ever injured or sustained any form of trauma or whiplash to your:

(circle all that apply) Jaw Head Neck None of these

(If any past trauma, please complete the trauma questionnaire)

Have you ever had stitches to your chin? Y N

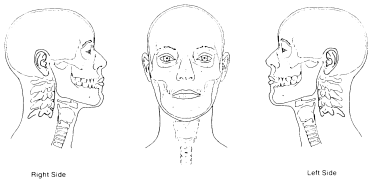
Do you feel there is any connection between the trauma you have had and the problems you are having? Y N

HeadA

10. Do you get headaches? Y N How often? _____

How long do they last? _____

Where does it ache? _____



11. Have you had any changes in your vision? Y N

Do you get visual disturbances along with headaches? Y N

ENT

Do you have problems with your ears? Y N

Dizziness? Y N Ringing? Y N

Hearing? Y N Other? _____

Have you noticed any lumps in your face, throat or neck? Y N

Do you typically breath through your mouth instead of your nose? Y N

Do you have any sinus problems? Y N

Explain: _____

12. Do you have trouble sleeping? Y N

Do you feel rested when you wake up? Y N

13. Do you have or have you had arthritis? Y N

Does anyone related to you have arthritis? Y N

Are your fingers sore or stiff? Y N

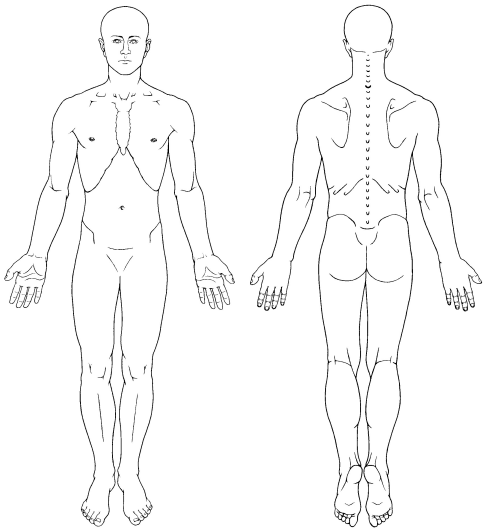
Any dry skin patches past or present? Y N

Any skin rashes past or present? Y N

Have you been treated for any other painful condition in the last three years other than your present problem? Y N

Explain _____

On the diagram below please indicate any other areas that are painful:



14. Have you had any prior treatment for TMJ problems? Y N

Appliance/Splint? Y N When? _____ Did it help? Y N

Night guard? Y N When? _____ Did it help? Y N

Bite adjustment? Y N When? _____ Did it help? Y N

Orthodontics? Y N When? _____ Did it help? Y N

Other _____

15. Please list, in chronological order, health care providers you have seen for the problem you are presenting with today:

Date	Doctor or provider	Treatment	Did it help?
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N

Please do not write in this space

Please do not write in this space

17. Describe the problem (s) in your own words:

_____

_____

_____

_____

_____

_____

_____

How have these problems affected your life? Does it keep you from doing anything that you want to do? (work, play, chores, eating, talking)

_____

_____

_____

What would you like to accomplish with treatment here?

#1 ii
cc

_____

_____

_____

_____

18. What has Changed and When:

So that I may have a better understanding of your problem, please list in chronological order with date estimates all the changes and/or defining moments of your problem. (Examples are: fell down stairs, left TMJ clicking started, clicking stopped, teeth shifted, headaches increased, headaches stopped, left ear pain.)

Date Estimate	Change that Occurred
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

19. Is there anything else that I should know about?

_____

_____

_____

_____

_____

_____

_____

20. So that I can better understand your pain, please complete the following:

What does your pain feel like? Some of the words below describe your present pain.

Circle all the words that describe it.

Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
Beating		Lancinating		Crushing
Pounding				
Tugging	Hot	Tingling	Dull	Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
Searing	Stinging	Aching	Splitting	
			Heavy	
Tiring	Sickening	Fearful	Punishing	Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	Cruel	
		Vicious		
Annoying	Spreading	Tight	Cool	Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawn	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

21. I have completed all 8 pages to the best of my knowledge and I personally have filled in each blank.

_____ _____

signature date

TRAUMA QUESTIONNAIRE

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drdroter @mac.com

Name _____Date_____

PLEASE ANSWER ALL QUESTIONS

I. Date of Trauma_____

Was your trauma from (circle one)

Auto accident Fight Fall Sports Injury Other

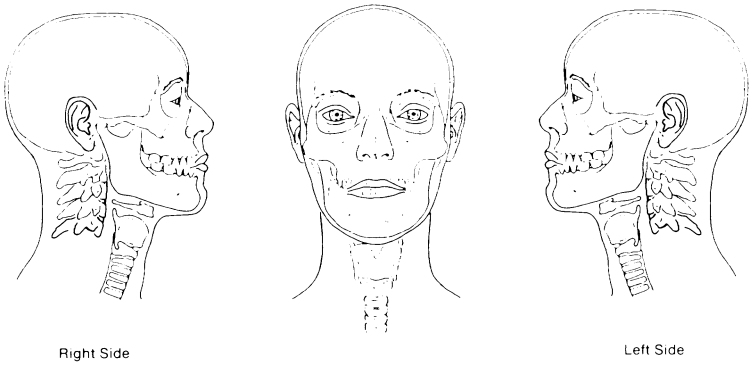
How did the trauma happen?_____

_____

_____

_____

On the diagram below draw an arrow to indicate the location



II. During the trauma, did you strike your (circle all that apply)

Skull Nose Chin Lower jaw Neck Chest

Other_____

Did you have whiplash? Y N

Which of the following did you have as a result of the accident?

Cuts Abrasions Bruises Bleeding from the mouth

Bleeding from the nose Bleeding from the ears

III. Were you knocked out? Y N How long ? _____

What was your first memory after the trauma?_____

_____

IV. Immediately post-trauma, were you treated (circle all that apply)

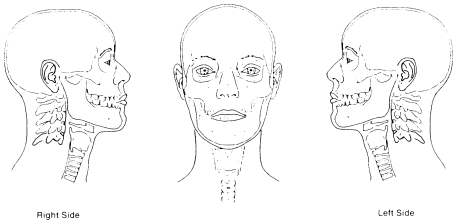
Emergency room Doctor's office Other _____

Name of facility_____

When were you first seen for evaluation after the trauma? _____

Please do not write in this space.

Trauma



V. What Hurt after the trauma? _____

_____

_____

VI. List all doctors who have treated you for this trauma and explain what they had done:

Emergency physician, Family Doctor , Physical therapist, Chiropractor, Dentist, Oral Surgeon, Neurologist, Psychologist

_____

_____

_____

_____

_____

VII. Did you have X-rays of the (circle all that apply)

Face Neck Skull Other_____

Did you have a CT scan? Y N

Did you have a MRI scan? Y N

What other tests did you have?_____

_____

VIII. Who do you feel is at fault for your trauma?_____

_____

Explain_____

_____

IX. Is your pain getting (circle one) Worse Better Unchanged

X. Do you have an attorney representing you? Y N

Your attorney's name_____

XI. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing.

_____ _____

Signature Date

Please do not write in this space.

Sleep/Fatigue Screening

_____
Name

_____
Date

_____
Age

Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*

1. I have been told I stop breathing while asleep	☐
2. I have fallen asleep or nodded off while driving	☐
3. I've woken up with shortness of breath / gasping or my heart racing	☐
4. I feel excessively sleepy or fatigued during the day	☐
5. I snore or have been told that I snore	☐
6. I have had weight gain and found it difficult to lose	☐
7. I have been diagnosed with high blood pressure	☐
8. It takes me less than 10 minutes to fall asleep	☐
9. I wake up more than 1 time per night	☐
10. I wake up with headaches	☐

Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

Tiredness: How likely are you to dose off in the following situations? Use the following scale to chose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation

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

Over the last 2 weeks have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling fatigued	0	1	2	3
Trouble falling asleep	0	1	2	3
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Abdominal discomfort and/ or bloating/fullness	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Stomach or gut rumbling	0	1	2	3

Sleep/Fatigue Questionnaire

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Bowie, Maryland, 20716
301-805-9400
drdroter@mac.com

Name _____Age_____

Date _____ Referred by _____

Referring Dr.'s Phone # and Email: _____

Please do not write in this space.

1. Do you have trouble sleeping? Y N

Do you feel rested when you wake up? Y N

Are you a light sleeper, awoken easily? Y N

Do you toss and turn in your sleep? Y N

Rate your overall daily energy level: Low Less than Before Normal High

How many hours of sleep do you get on average per night ____ hours

How many hours of sleep would you like to get? ____ hours

Circle: It takes me on average about: 5 10 15 20+ minutes to fall asleep.

Choose: __ I sleep through the night __I wake in middle of sleep on average_____ times a night.

Check all that apply to what wakes you:

__ Need to go to the bathroom __ Pain __ Sleep partner

__ Legs muscle spasm __ Room noise __ Other- _____

In which position do you sleep: Back Side Stomach

Do you take any medications to help you sleep? Y N

Please List: _____

Do you snore? Y N

Do you have a sleep partner? Y N

Does your sleep partner snore? Y N

Do you sleep in a different room as your partner? Y N Sometimes

Do you have any trouble breathing during sleep? Y N

Have you ever woken up gasping or choking? Y N

Are your legs comfortable when you sleep? Y N

Do you consider yourself under a lot of stress? Y N

Do you worry? Y N

Do you ever get depressed? Y N

How often? _____

2. Do you typically breath through your mouth instead of your nose? Y N

Do you have any sinus problems? Y N

List _____

3. Have you ever had a stomach problem? Y N

Ulcers GERD Acid Reflux Y N

Rate the nutrition of your diet: Excellent Good Could be better Poor

Do you use vitamin supplements? Y N

Women: do you take an iron supplement? Y N

Do you exercise? Y N

Do you currently use (circle): Caffeine Alcohol Tobacco products Nicotine

Amount of Caffeine per day: _____

Amount of Alcohol: _____

4. Check all that apply:

__ I go to bed most nights at the same time. __ My sleep schedule is inconsistent.
__ I wake up most days at the same time
__ I do not need an alarm to wake up most days __ I need an alarm to wake me up

Check all that apply about the room you sleep in:
__ Room is quiet __ Room is noisy
__ My sleep partner snores __ My sleep partner tosses and turns
__ Room is dark __ I watch TV in bed
__ Room temperature is comfortable __ Room is too warm __Room is too cold

Check all that apply to you when you sleep:
__ Feet are comfortable temperature __ My feet are cold __ I wear socks
__ Body is comfortable temperature __ Body is too warm __ I sweat
__ Body is cold __ I wear extra clothes

Check all that apply about your evening meal:
__ I eat a small dinner __ Dinner is my largest meal of the day.
__ I eat early __ I eat dinner late 3+ times a week
__ I often skip dinner __ I have snack in the evening before bed

Circle which of the following you have done in the past 2 weeks in the HOUR prior to sleep:
Read a book, magazine Eaten food Watched TV On computer, Tablet, phone
Meditation Stretching other_____

5. Date of last medical physical: _____

Have you had a Sleep Test by a Physician? Y N Date of sleep test: _____

Were you diagnosed with Obstructive Sleep Apnea? Y N Was CPAP recommended? Y N

CPAP Use (circle all that apply): Every Night Most nights. Some Nights Not used

When CPAP is used, how long is it worn? All night Half the night

Please do not write in this space.

6. Do you get headaches? Y N

How often? _____

Do you clench your teeth? Y N

Do you grind your teeth? Y N

Any discomfort when you move your jaw? Y N

Any discomfort upon chewing hard foods like carrots? Y N

Please do not write in this space.

7. What would you like to improve with treatment here?

_____

_____

_____

_____

8. Is there anything else that I should know about?

_____

_____

_____

_____

_____

_____

_____

10. I have completed all 3 pages to the best of my knowledge and I personally have filled in each blank.

_____ _____

signature date

MEDICAL AND DENTAL HISTORY

Please fill in the spaces below as accurately as possible. For your safety, it is necessary as part of any complete examination to know about your general health. This material will, of course, be held confidential.

NAME_____ Date of Birth_____

1. Are you under a physicians care?_____ Family physician_____
2. Are you taking any type of medication?_____ Please list_____

_____

3. What is your sensitivity to medications? I need ( ) More ( ) Less ( ) Same dose of medication compared to others.
4. Are you allergic to any of the following? (Please check)
   Codeine ( ) Aspirin ( ) Novocaine ( ) Penicillin ( ) Latex ( ) Other_____
5. Have you ever had or do you have: (Please check)

Heart Trouble	( )	Bleeding or Clotting Problem	( )	Sinus Trouble	( )	Arthritis	( )
Heart Attack	( )	Shortness of Breath	( )	Persistent Cough	( )	Physical Handicap	( )
Stroke	( )	Hepatitis (Jaundice)	( )	Lung Trouble	( )	Cancer	( )
Anemia	( )	Tuberculosis	( )	Asthma	( )	Kidney Trouble	( )
Chest Pains	( )	Diabetes	( )	Emphysema	( )	Thyroid Problems	( )
Osteoporosis	( )	High Blood Pressure	( )	Fainting Spells	( )	Epilepsy	( )
Seizure	( )	Low Blood Pressure	( )	Allergies	( )	Leukemia	( )
Liver Trouble	( )	AIDS /HIV +)	( )	Glaucoma	( )	Venereal Disease	( )
				Stomach Ulcers	( )	Chemical Dependency	( )

6. Height _____ Weight _____
7. Have you had any serious illness or been hospitalized in the last 5 years?_____

   Describe_____
8. Have you ever been given anesthesia before (put to sleep)? YES NO

   Describe_____
9. Do you smoke? YES NO Do you chew tobacco? YES NO
10. (Women) Are you pregnant? YES NO Are you taking birth control pills? YES NO

11. When was your last visit to the dentist?_____
12. Have you ever had or do you now have: (Please check)

Problems with dental treatment	( )	Bleeding Gums	( )	Problems with anesthetics	( )
Pain in teeth or jaws	( )	Periodontal disease	( )	Food catching between teeth	( )
Clench or Grind your teeth	( )	Bruise easily	( )	Injuries to teeth or jaw	( )
Clicking or pain in the jaw joint	( )	Gag easily	( )	Sensitivity to sweets, biting	( )
Headaches	( )	Snoring Problem	( )	Sensitivity to hot or cold	( )
Jewelry or metal sensitivity	( )				

13. How often do you brush your teeth?_____ Floss them?_____
    What type of toothpaste do you use? _____ Mouthwash? _____
14. Do you have missing teeth?_____ Why were they not replaced?_____
15. Have you ever had a bad experience in a dental office?_____
16. What part of dentistry do you find most unpleasant?_____
17. Please describe any dental problem that is bothering you at this time._____

_____

BP _____ _____ Signature of patient or guardian _____ Date

Patient Information

This information is needed to create forms that you can submit to your insurance carrier. All information is confidential.

John R. Droter, D.D.S.
4000 Mitchellville Rd #B330
Bowie, Maryland 20716

Name: Birthday:

Address:

City,State Zip:

Home Phone: Work Phone:

Cell Phone: E-mail we can send your medical information to:

Employers Name and Address:

Whose name is the insurance in (Primary policy holder) ? Relationship?

Primary policy holder Date of Birth

Insurance Company Name Policy ID # Group #

Spouses Name: Spouses Work Phone:

Consent Agreement:

1. I hereby authorize the doctor or designated staff to take xrays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. If further information is needed you have my permission to ask the respective health care provider or agency, who may release such information to you.
3. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
4. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
5. ❒ I do ❒ I do not Consent to sending your referring doctor a report of our findings.
6. Dr. Droter teaches other professionals. Your assistance in allowing him to document your case will benefit many other patients.
   ❒ I do ❒ I do not Consent to the anonymous use of my x-rays, records, and photographs for scientific teaching, research, and/ or publication. (Your name will not be used.)
7. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. I authorize the doctor to obtain a financial credit report if credit will be extended.

(Signature) (Date)

SIGNS AND SYMPTOMS OF TMJ DISORDERS

1. *Headaches, especially headaches around the temple and behind the eyes. It has been estimated that up to half of all headaches are TMJ related.*
2. *Grinding or clenching your teeth, especially at night.*
3. *Sore muscles of the jaw and neck. Tired muscles after eating. Sore muscles from clenching or grinding your teeth.*
4. *Pain or tenderness of the TMJ.*
5. *Any present or past clicking noises from your TMJ.*
6. *A rough, sand like, gravely sound of the TMJ upon movement.*
7. *A past history of limited opening. Not being able to open your jaw as far as you could in the past. Not being able to open or close your jaw without moving it sideways.*
8. *Any signs of excess force on the teeth, including;*
   Teeth that are wearing away.
   Teeth that are chipping or breaking.
   Teeth that are cracking or splitting.
   Teeth that are moving.
   Teeth that are loose.
9. *Ear ache, throbbing, or ringing.*
10. *Pain behind the eyes*
11. *A change in the bite. The teeth do not feel like they fit together properly.*

NOTE: Pain is not a good indicator of the severity of the disease. A joint with minor damage may hurt worse than a joint that is completely destroyed.

Commonly Asked Questions

I have headaches. Is there a chance that it is due to the TMJ?

Many headaches are related to a problem with either the TMJ or the muscles of the TMJ. Many patients who had suffered for years with headaches are now pain free after their TMJ problem was accurately diagnosed and treated.

My jaw joint clicks occasionally. Do I need treatment?

You can not have clicking in the TMJ without having damaged the ligaments that once held the disc in place. The extent of the damage needs to be determined. Not all clicks of the TMJ need to be treated, but some must be to avoid future problems. You must have a doctor who is knowledgeable in TMJ problems evaluate you. A severely damaged joint and a slightly damaged joint can surprisingly appear quite similar. Seeking treatment now may prevent the disease process from progressing into its more painful and destructive stages.

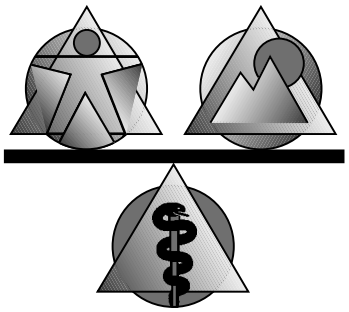
Occasionally my jaw gets stuck and I can not open very wide. If I wiggle my jaw, that frees it up sometimes. Sometimes it does not. What is happening?

Get an examination immediately by a doctor who is knowledgeable in treating TMJ problems. Your TMJ is entering a more advanced stage of breakdown. The disc is getting stuck out of its normal position. Intervention now may prevent you from entering the more serious forms of this disease process.

I grind my teeth at night. I guess I am under too much stress. Is there anything that can be done?

While stress will cause the amount of grinding to increase, it is usually not the primary cause of the grinding. A clinical examination usually will reveal the cause of the grinding. Common causes of grinding are an uneven bite or a damaged TMJ.

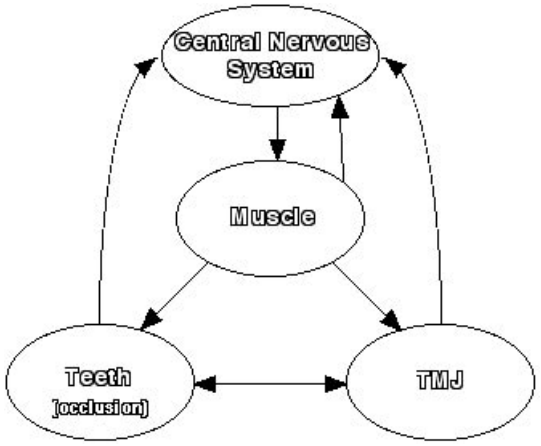
TEMPORO-MANDIBULAR JOINT DISORDERS



Do you have a TMJ problem?

JOHN R. DROTER, D.D.S.

Illustrations by:
John R. Droter, D.D.S.
Gretta Tomb O'Brien, D.D.S.



TMJ Disorders are Multifactorial

Temporomandibular joint (TMJ) disorders involve the joint between the mandible (jaw bone) and the temporal bone of the skull. While there are many different problems that can cause pain or discomfort in the head and neck area, TMJ disorders refer to when there is actual damage and breakdown in the TMJ. The breakdown can occur in the bone, disc, ligaments, and cartilage of the joint, affecting the way the joint functions.

A healthy TMJ works in harmony with the muscles of the head and neck, the teeth and the central nervous system (CNS). All 4 entities are dependent on the others to work properly (see diagram above). Any problem in one area will create problems in the other areas.

- TMJ disorders are any disharmony of this system.
- Treatment is aimed at reestablishing harmony between all four areas.

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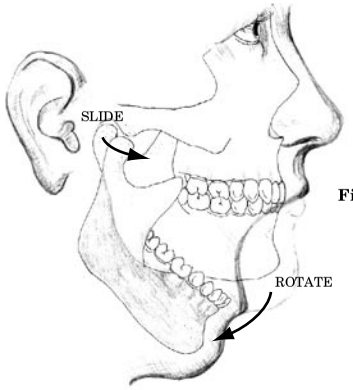


Figure 1-1

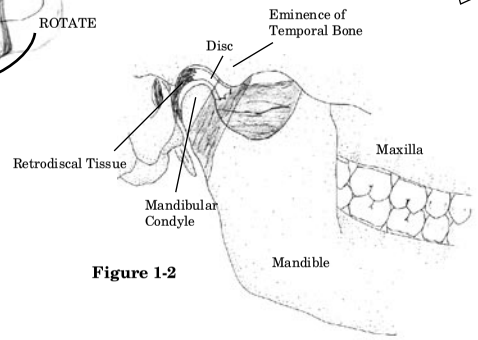
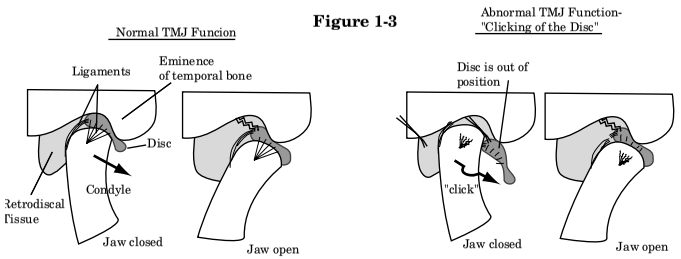


Figure 1-2

Figure 1-3



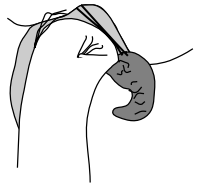
How The TMJ Works

A joint is the connection between two bones that allows movement between those bones. A healthy joint will be able to move smoothly, without pain, through a full range of motion.

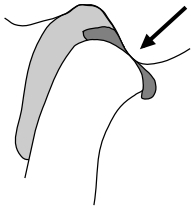
The TMJ is located in front of the ears. It connects the temporal bone of the skull with the mandible (jaw bone), and allows movement between the two bones. (See figures 1-1, 1-2, 1-3) The TMJ consists of both soft tissue (disc,ligaments, capsule, and retrodiscal tissue), and bone (condyle and eminence). Both can undergo breakdown.

The joint allows you to move your jaw open and close, left and right, and forward and back, so that you may chew, speak, and swallow. The TMJ is actually two joints (a left and a right) that must work in harmony with each other and with the muscles to allow these movements. Each joint is capable of three types of movements; rotating, sliding, and pivoting. If you place your fingers in front of your ears and open and close, you can feel the TMJ and the condyle. Notice that if you only open a small amount and then close, the jaw rotates like a hinge. When you push your lower jaw forward without opening, you will feel it slide. When you open real wide, the jaw both rotates and slides forward. If you move your jaw to the left, the right joint will slide and the left joint will pivot. This is the only joint in the body that rotates, slides, and pivots. If there is any problem with either the joint, disc, ligaments, or bone, then you have a TMJ disorder. Any discomfort when you touch the joint, even very slight discomfort, is an indication that something is wrong. The joint is meant to operate smoothly and pain free.

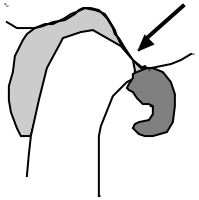
Various types of TMJ BREAKDOWN



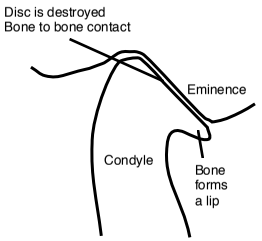
Disc stuck forward
can not open wide



Disc perforation-
A hole is worn through the disc and bone is rubbing against bone.



Retrodiscal perforation-
A hole is worn through the retrodiscal tissue.



Osteoarthritis of the TMJ

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Bowie, Maryland, 20716
301-805-9400
drdroter@mac.com

Concerning First Appointment and Fees

Many people find it helpful to know what they can expect from a time and financial prospective. Below is an attempt to give you an overview of what you might expect. Let us know if you are encountering any obstacles so we may help.

First Appointment- Is usually a preliminary evaluation of your problem. A history of the problem is taken. The head and neck are examined. Preliminary diagnostic test such as doppler auscultation and range of motion are performed. This will usually take about an hour.
The goal of the first appointment is to answer these questions:

Is the TMJ damaged?
Is the Neck Damaged?
Does this damage contribute to the problems you are having?
What further tests or radiographs, if any, are needed, to develop a definitive diagnosis?

You will be informed and educated as to what your problem might be, and will be given a plan on how best to reach a definitive diagnosis. In some cases, Dr. Droter figures out what the problem is at this appointment and treatment can be initiated. However, most cases require additional information. Once we have an accurate diagnosis, a specific treatment to your specific problem can be chosen. If this is an emergency exam, some form of treatment may be rendered at the first appointment.

Cost Estimate of first appointment

- $1,380 for new patient preliminary evaluation.
- You will need to pay the full amount at the time of the appointment.
- Cash, Checks or Credit Cards (Master Card, Visa, Discover) are accepted.

Insurance information- There are so many different insurance plans, that it is impossible for us to know what your plan covers. You will need to speak with your insurance company to find out the specifics. Your insurance company is suppose to have staff available to help you submit claims. Some information you may find helpful in speaking with them:

- You may need a referral from your primary care medical doctor before seeing Dr. Droter to get coverage.
- Dr. Droter is a dentist who diagnoses and treats medical conditions of the head and neck.
- The first appointment is considered an orthopedic evaluation of the head and neck, which is a medical evaluation.
- Coverage for Dr. Droter will be in the non-participator category.
- You will be given an insurance form to send into your medical insurance carrier.
- Any benefits you are due need to be sent to you directly from your insurance carrier.

MEDICARE
PRIVATE CONTRACT

By signing this contract I understand and agree that I will not submit (or request that my general dentist submit) a claim to Medicare or its agents for services provided by **John R. Droter,DDS**, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by **John R. Droter,DDS**, and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by my general dentist for services provided.

I understand that Medigap plans do not, and other health and medical care insurance plans may elect not to, make payments for such services.

I understand that I have the right to have services provided by other general dentists or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that **John R. Droter,DDS** is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on _____, and it will not expire until the patient is released from Treatment with **John R. Droter,DDS.**

Patient Name: _____

Patient's Signature: _____

General Dentist's Signature: _____

John R. Droter, DDS
HIPPA Notice of Private Practices

This disclosure describes how health information about you can be used and how you can get access to this information. Please review it 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 takes effect April 13, 2003, 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 we created or received before we made the 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

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 with 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, 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 may 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 (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 in your care. 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 health or safety or 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, 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 practicably 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 using 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 $0.00 for each page, $ 25.00 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 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 April 14, 2003. If you request this more than once is 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, 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 buy alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Question and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Amanda Miller Telephone: 301-805-9400
John R Droter, DDS
4000 Mitchellville Rd., 330B
Bowie, MD 20716

.....

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement*

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

_____ Signature _____ Date

.....

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Directions to Our Office

John R. Droter, D.D.S.
4000 Mitchellville Rd,
 # B330
Bowie, MD, 20716

301-805-9400
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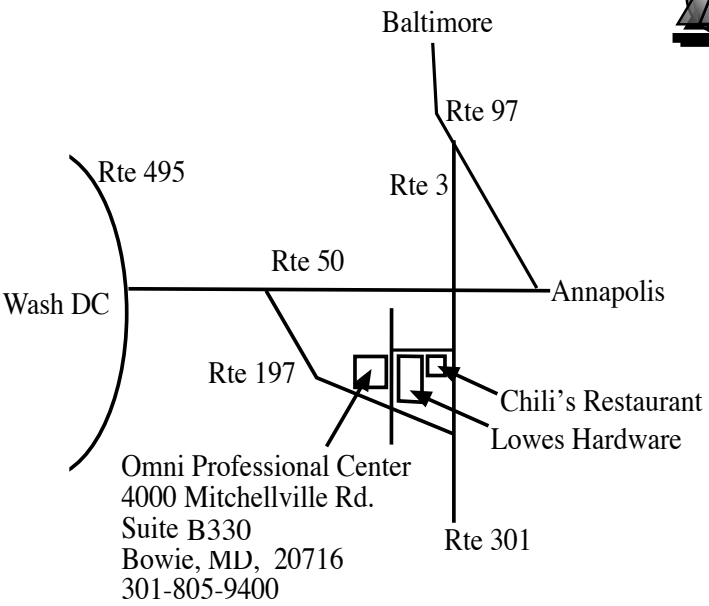

From Washington, DC take Rte. 50 East
- to exit 13A- Rte. 301 South
- at 2nd traffic light make a right on to Heritage blvd
  (Chili's restaurant on corner)
- at stop sign make a left on to Mitchellville Rd
- then an immediate right into our parking lot
  Omni Professional Center (4 story brick and glass office building)

From Baltimore, MD take Rte. 97 South
- to Rte 50 West
- to exit 13A- Rte. 301 South
- at 2nd traffic light make a right on to Heritage blvd
  (Chili's restaurant on corner)
- at stop sign make a left on to Mitchellville Rd
- then an immediate right into our parking lot
  Omni Professional Center (4 story brick and glass office building)

From Annapolis, MD take Rte. 50 West
- to exit 13A- Rte. 301 South
- at 2nd traffic light make a right on to Heritage blvd
  (Chili's restaurant on corner)
- at stop sign make a left on to Mitchellville Rd
- then an immediate right into our parking lot
  Omni Professional Center (4 story brick and glass office building)

From Waldorf, MD take Rte. 301 North
- at the next light after Rte 197, make a left on to Heritage blvd
  (Chili's restaurant on corner)
- at stop sign make a left on to Mitchellville Rd
- then an immediate right into our parking lot
  Omni Professional Center (4 story brick and glass office building)