Premier Dental and ORAL HEALTH GROUP, p.c.
Ronald E. Massie, D.D.S, M.A.G.D.

REGISTRATION INFORMATION

PATIENT INFO:

Name: _____ Sex: M F Name you go by: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: (____) _____ Cell Phone:_____

Best Way to Contact You: Home Phone Cell Phone Work Phone Email Text Message

Social Security # _____-_____-_____Date of Birth: _____/_____/_____

Driver's license number:_____State:_____

Email Address:_____ Marital Status: Single Married Separated Widow

Employer:_____ Business Phone: (____) _____

Occupation:_____ Are you a full time student? Yes No

SPOUSE INFO (PARENT IF PATIENT IS UNDER 18 YEARS OLD):

Name:_____ Social Security # _____-_____-_____

Employer:_____ Business Phone: (____) _____

Dental Insurance:

_____
Carrier Policy # Group # Policy Holder Date of Birth SS#

_____
Other Dental Insurance Policy # Group # Policy Holder Date of Birth SS#

All fees and charges are due and payable on the date of service unless other arrangements have been made. *The fee for a missed appointment is $114.00 per ½ hour scheduled and canceled or not kept within 24 hours of appointment time.*

Premier Dental & Oral Health Group, P.C., considers insurance coverage as an agreement between the patient, the insurance company and the employer, where applicable. Premier Dental & Oral Health Group, P.C. is not a part to that agreement, and as a result, is not bound by any of the covenants, limitations, or restrictions of that policy, unless she/he is a provider for my particular insurance carrier. I also understand that I am responsible for all non-covered services pertaining to my particular insurance carrier.

Should outstanding charges remain unpaid and my account placed in the hands of an attorney or a collection agency. Interest shall be charged on past due invoices at the rate of 1.5% per month (18% per annum.) In the event it becomes necessary to turn your account(s) over to a collection agency or use an attorney, I (we) promise to pay, in addition to the amount due, collection fees in an amount up to 50% of the principle balance, all court cost and reasonable attonery fees. The parties agree that the jurisdiction for any dispute under this contract shall be the County of Camden or Miller, MO.

I hereby authorize the release of any medical information necessary to process and consider health/dental insurance claims submitted on behalf of myself and/or dependents by Premier Dental & Oral Health Group, P.C. I authorize payment of benefits due on such claims to be made directly to the provider of services should the provider choose to accept assignment on the claims submitted. These authorizations apply to all private, group and government health plans and are ongoing from this date forward unless revoked in writing. Photocopies of this authorization will be as valid as the original authorization.

Having read and understood the above statements, I agree to the terms set forth.

Date: _____ Signature: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health (i.e. fever, new cough) __	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches_____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed?_____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?_____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years?_____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you frequently get food caught between any teeth?_____ ☐ ☐

GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you EVER smoked? ☐Yes ☐No

(If No, proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

☐ None (quit smoking completely) ☐ Less than 1 pack of cigarettes per day ☐ An occasional cigar
☐ An occasional cigarette ☐ 1-2 Packs of cigarettes per day ☐ Cigars on a daily / regular basis
☐ A few cigarettes per day ☐ 2 or more packs of cigarettes per day ☐ Occasional pipe smoker
☐ A pipe on a daily / regular basis

If you have quit smoking, when did you quit?

☐Less than 6 months ago ☐ 6 months to a year ago ☐1 to 3 years ago ☐Over 3 years ago

How many years have you or did you smoke?

☐Less than 2 years ☐2-5 years ☐5-10 years ☐10-20 years ☐Over 20 years

2. Do you / Have you EVER chew/chewed tobacco or use/used snuff or other similar substance? ☐Yes ☐No

(If No, proceed to question 3)

Are you STILL using smokeless tobacco or snuff? ☐Yes ☐No

If No, WHEN did you quit?

☐Less than 6 months ago ☐6 months to a year ago ☐1 to 3 years ago ☐Over 3 years ago

How many years did you use or have you used smokeless tobacco?

☐ Less than 1 year ☐ 1-2 years ☐ 2-5 years ☐ Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

☐None ☐Less than 1 per week ☐1-5 drinks ☐ 6-11 drinks ☐11-20 drinks ☐ Over 20 drinks

4. Do you have or have you ever had a substance abuse problem? ☐Yes ☐No

Describe_____

5. Do you presently use any recreational drugs? ☐Yes ☐No

List_____

6. Do you have or have you ever had an eating disorder? ☐Yes ☐No

If Yes, Please Specify: _____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) ☐Yes ☐No

List _____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? ☐Yes ☐No

9. Please list your history or any family member's history of cancer:

_____

_____

10. Other concerns and considerations:

_____

_____

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____

Premier Dental and Oral Health Group, P.C.
SLEEP QUESTIONNAIRE

1. Do you or has someone told you that you snore? ◯ YES ◯ NO
2. How often do you sleep through the night? ◯ EVERY NIGHT ◯ SOME NIGHTS ◯ NEVER
3. When was the last time you dreamt? ◯ LAST NIGHT ◯ FEW TIMES PER WEEK ◯ DON'T REMEMBER
4. When you dream are they ◯ PEACEFUL ◯ WEIRD ◯ A BEAR CHASING YOU THROUGH THE WOODS?

5. How many hours do you sleep before you wake up for any reason? ◯ 2 ◯ 4 ◯ 6 ◯ 8
6. When you awaken in the middle of your sleep time, the reason is usually for what?
   ◯ JUST BECAUSE ◯ A LOT ON MY MIND ◯ BATHROOM NEEDS ◯ OTHER_____
7. What have you tried to get better rest? ◯ MEDS ◯ HERBALS ◯ FOOD ◯ OTHER_____

8. What time do you usually go to bed? ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ A.M. ◯ P.M.
9. How long after you shut the lights off does it take you to go to sleep?
   ◯ IMMEDIATELY ◯ FEW MINUTES ◯ 30 MINUTES ◯ AN HOUR ◯ SEVERAL HOURS
10. Are you constantly tired? ◯ YES ◯ NO
11. Do you require a nap? ◯ DAILY ◯ WEEKLY ◯ ONCE A MONTH ◯ NEVER
12. What time do you normally eat dinner before you go to bed? _____
13. What time do you usually get up in the morning? _____
14. If you could change one thing about how you sleep, what would that be?
    _____
    _____
    _____

_____
Patient Name

_____ _____/_____/_____
SIGNATURE DATE

_____ _____/_____/_____
DOCTORS SIGNATURE DATE

PREMIER DENTAL & ORAL HEALTH GROUP, P.C.

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a 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 a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

Patient Name: _____ Date:_____

CRA FORM

First name: _____ Last name: _____ Date: _____

Adults and Children Age 6+

Due to new research on cavities and what causes them, we know everyone is at risk of developing decay at some point during their lifetime. The goal of this assessment form and the bacterial screening test is to determine your likelihood of experiencing new decay in the next 12 months. Please fill out the "Patient Use" section of this form to the best of your ability. These items will be discussed with your dental professional during your appointment today. Questions about this form? See the back for Q&A.

PATIENT USE

Would you like a free bacterial screening test to help determine your risk for cavities? (The test is a quick, painless swab of your teeth.)	◯ **yes**		◯ **no**
If diagnosed at risk for cavities today, would you be interested in discussing treatment options?	◯ yes	◯ maybe	◯ no
If needed, are you willing to modify your dietary habits?	◯ yes	◯ maybe	◯ no

RISK FACTORS

Do you notice plaque build-up on your teeth between brushings?	◯ no	◯ yes
Do you take medications daily? If yes, how many? (#____)	◯ no	◯ yes
Do you feel like you have a dry mouth at any time of the day or night?	◯ no	◯ yes
Do you drink liquids other than water more than 2 times daily between meals?	◯ no	◯ yes
Do you snack daily between meals?	◯ no	◯ yes
Do you have oral appliances present?	◯ no	◯ yes
Do any of these other health concerns apply to you? (check all that apply) Frequent tobacco use — Other drug use Acid reflux — Bulimia Diabetes — Sjogren's Syndrome Head/neck radiation therapy	◯ no	◯ yes

CLINICIAN USE ONLY

DISEASE INDICATORS

New/Progressing Visible Cavitations	◯ no	◯ yes
New/Progressing Approximal Radiographic Radiolucencies	◯ no	◯ yes
New/Active White Spot Lesions	◯ no	◯ yes
Decay History is a Concern	◯ no	◯ yes

BIOFILM CHALLENGE

CariScreen Bacterial Assessment (0-1500 low, 1501-9999 high)	◯ low	◯ high

PROFESSIONAL ASSESSMENT SUMMARY

Risk Factors are a Concern	◯ no	◯ yes
Disease Indicators are a Concern	◯ no	◯ yes
Biofilm Challenge is a Concern	◯ no	◯ yes

RISK IDENTIFICATION

Transfer information above to boxes below to determine risk.

N Y Risk Factors Disease Indicators Biofilm Challenge	N Y Risk Factors Disease Indicators Biofilm Challenge	N Y Risk Factors Disease Indicators Biofilm Challenge	N Y Risk Factors Disease Indicators Biofilm Challenge	N Y Risk Factors Disease Indicators Biofilm Challenge
LOW RISK	**MODERATE RISK**	**HIGH RISK**	**HIGH RISK**	**HIGH/EXTREME RISK**
1	**2**	**3**	**4**	**5**

RECOMMENDED __ PROVISIONAL __ DECLINE

PREMIER DENTAL & ORAL HEALTH GROUP

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:
DENTAL INFORMATION

Persons Authorized to Use or Disclose Information:
Information listed above will be used or disclosed by:
PREMIER DENTAL & ORAL HEALTH GROUP
Name of person or organization

Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Name of person or organization

Name of person or organization

Expiration Date of Authorization
This authorization if effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Premier Dental & Oral Health Group. You should contact the Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or type)

Signature of Patient

Signature of Patient Representative

Relationship of Patient Representative to Patient

RECORDS RELEASE

Date_____

TO_____

_____

I hereby authorize you to release to:

Premier Dental & Oral Health Group, P.C.
Ronald E. Massie, D.D.S., M.A.G.D.
24 North Shore Dr.
Lake Ozark, MO 65049
573-365-0220 FAX 573-365-1962
patientcare@thepremierdentalgroup.com

any information including the diagnosis and records of any treatment or examination rendered to me. (perio chart, chart notes, x-rays)

_____
SIGNATURE

_____ _____

WITNESS PATIENT'S NAME & DOB

If you feel you have gum issues, please fill out this form.

PREMIER DENTAL AND ORAL HEALTH GROUP, P.C.

RONALD E. MASSIE, D.D.S., M.A.G.D.

PERIODONTAL (GUM) HISTORY

	YES	NO
Do you feel that your gums are shrinking back from your teeth?	○	○
Do you have bad breath that you can't solve?	○	○
Do your gums bleed when you brush every time?	○	○
Have you ever been told that you have gum disease?	○	○
Did your parents have gum disease?	○	○
Have you ever been referred for gum disease to a specialist?	○	○
Have you ever been treated for gum disease?	○	○

How long ago? _____YEARS

Tell us how you take care of your mouth and gums....

- **BRUSH ____TIMES PER DAY**
- **FLOSS _____TIMES PER** ○ **DAY** ○ **WEEK** ○ **MONTH**
- **MOUTHWASH** ○ **DAILY** ○ **WEEKLY** ○ **MONTHLY**
- **TOOTHPICK** ○ **AFTER EVERY MEAL** ○ **DAILY** ○ **WEEKLY** ○ **AS NECESSARY**

Other types of care that you do?

_____

_____

_____

_____

If you feel you have jaw issues, please fill out this form.

TMJ AND OCCLUSION SURVEY

YES	NO	
◉	○	1. Do you have frequent headaches/migraines?
○	◉	2. Do you have pain in or around your jaw joints? ○ Left ○ Right When did you first notice the jaw pain? _____
○	○	3. Has the pain recently become more severe?
○	○	4. When is the pain worse? ○ Mornings ○ Evenings ○ At Meal
○	○	5. Do you have tired jaw muscles? ○ In the Mornings ○ In the Evenings
○	○	6. Do you have: ○ Tooth Sensitivity to Cold ○ Air ○ Chewing
○	○	7. Do you have clicking, popping or grating noises in your jaw joint? ○ Left or ○ Right
○	○	8. Does your jaw problem interfere with your normal activities?
○	○	9. Have you had treatments for this problem? When/Where?_____
○	○	10. Are you taking antidepressants or any medication that may affect muscle activity or cause dry mouth?
○	○	11. Have you ever had a severe blow, whiplash or trauma to the head, neck or jaw? Explain:_____
○	○	12. Do you have difficulty chewing? This results in pain in joint, in teeth, limited opening, other (specify)_____
○	○	13. Has your mouth ever locked open so you were unable to close? When?_____
○	○	14. Has your mouth ever locked closed so you were unable to open? When?_____
○	○	15. Are you aware that you do either? ○ Clenching ○ Grinding
○	○	16. Have there been recent changes in your lifestyle or other stressful events?
○	○	17. Do you think nervous tensions seem to affect this problem?
○	○	18. Have you had orthodontic (braces) tooth alignment?
○	○	19. Do you sleep through the night?
		20. When was the last time you dreamt?_____
		21. How many nights a week do you dream?_____
		22. Are your dreams: ○ Stressful or ○ Peaceful
○	○	23. Do you have difficulty falling asleep?
○	○	24. Do you watch T.V. before bedtime?
○	○	25. When you awake in the night for any reason, can you go right back to sleep?
○	○	26. Do you feel constantly tired/exhausted?
○	○	27. Have you gained more than 10 pounds in the last year?
○	○	28. Do you often feel that you can't stay awake in the afternoon?
		29. What are your main goals for Occlusal/TMJ treatment?

_____

_____

_____