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Craniofacial Pain Associates
North Texas' preferred choice for effective TMJ relief

PATIENT REGISTRATION

Please print clearly and bring completed to your appointment.

Patient's name:_____ Date:_____
Street Address:_____ Apt. #:_____
City:_____ State:_____ Zip:_____
Birthdate:_____ Sex:____ Marital Status:_____ DL #:_____ SS #:_____
Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____
E-mail:_____ Fax:(____)_____
Employer's Name:_____ Dept.:_____
Business Address:_____ City:_____ State:_____ Zip:_____
Spouse / Parent / Guardian's Name:_____
Street Address:_____ Apt. #:_____
City:_____ State:_____ Zip:_____
Birthdate:_____ Sex:____ DL #:_____ SS #:_____
Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____
Employer:_____ Dept.:_____
Business Address:_____ Suite #:_____
City:_____ State:_____ Zip:_____
Emergency Contact:_____ Phone:(____)_____

If patient is a minor, please list other parent's name, business address and phone number:

_____

Referred By:_____ Phone:(____)_____
Street Address:_____ Suite #:_____
City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Are you a Medicare recipient? Yes___ No___ Primary___ Secondary___ Medicare #:_____
Medical Insurance:_____
Ins. Co. Address:_____
City:_____ State:_____ Zip:_____
Contact Person:_____ Phone:(____)_____
Policy Holder's Name:_____ Birthdate:_____ Relationship:_____
Policy #:_____ Group #:_____ ID #:_____

Dental Insurance:_____
Ins. Co. Address:_____
City:_____ State:_____ Zip:_____
Contact Person:_____ Phone:(____)_____
Policy Holder's Name:_____ Birthdate:_____ Relationship:_____
Policy #_____ Group #_____ ID #_____

HISTORY

Patient's Name:____ Height:________Weight:_________
Chief Complaint (Why are you here?):____

____

When did your symptoms first appear?____
Are these symptoms the result of an accident?________Date of Accident:_________________________
Was the accident work-related?_______Is worker's compensation to be filed?______________________
Please explain the accident completely:____

____

____

Please circle the correct answer:

1. Are you now receiving any kind of health care? Yes No
   If yes, please explain____
2. Have you been hospitalized or seriously ill in the last two years? Yes No
   If yes, please explain____
3. Please give a history of all surgeries, including dates:________________________________
   ____
   ____
   ____
4. Are you presently taking any medication? Yes No
   If yes, please list:____
   ____
5. Have you ever had a bad reaction to any medication? Yes No
   If yes, please list:____
6. Do you have or have you had abnormal bleeding? Yes No
7. Do you have excessive urination and/or thirst? Yes No
8. Do you have a heart pacemaker? Yes No
9. For women: Are you or do you suspect you are pregnant? Yes No
10. Do you have chronic neck or shoulder pain? Yes No
11. Have you ever worn a TENS unit? Yes No
    If yes, where on your body?________________ Did it help? Yes No
12. Have you ever had any physical therapy? Yes No
    If yes, where on your body?________________ Did it help? Yes No
13. Have you had trigger point injections in your muscles? Yes No
    If yes, where on your body?________________ Did it help? Yes No
14. Have you had biofeedback training or stress counseling? Yes No
15. Have you ever had psychiatric care? Yes No
16. Do you feel you have more stress in your life than most people? Yes No
    If yes, why?____
17. Mark on the line where you would rate your pain:
    0- -10
18. Is the pain worse in the ____ morning, ____ noontime, ____ evening, ___ night or ____ constant?
19. Do you have frequent and/or severe headaches? Yes No
    If yes, what relieves them?____
20. Describe your exercise program.____
    ____

(See next page)

Patient's Name:_____ Date:_____

21. Does your jaw make noises? Yes No
    Right: Clicking Popping Gritty or Squishy Noises Other _____
    Left: Clicking Popping Gritty or Squishy Noises Other _____
22. When did the noises begin?_____
23. Do you have pain in your jaw joints, ears, or sides of face? Yes No
24. Are you aware of anything that makes your pain worse? Yes No
    If yes, what?_____
25. Are you aware of anything that makes your pain better? Yes No
    If yes, what?_____
26. Has your jaw ever locked? Yes No
    If yes, when did this first occur?_____
    How often has this occurred?_____
27. Do you clench, grind or brux [gnash] your teeth? Yes No
28. Do your teeth or jaws ever feel "tired" when you wake up? Yes No
29. Do you have loose or sensitive teeth? Yes No
30. Have you ever been examined for or told you have a TMJ or "Jaw Joint" problem? Yes No
31. Have you ever worn a splint or night guard? Yes No Upper Lower Did it help? Yes No
    Who made it for you and when?_____
32. Have you ever had periodontal disease [pyorrhea] or gum surgery? Yes No
33. Have you ever had orthodontic treatment or braces? Yes No
34. If you have been <u>diagnosed</u> with any of the following, **please mark "C" for current and "P" for past.**

_____ A.I.D.S.	_____ Epilepsy	_____ Malignancies
_____ Acrylic allergy	_____ Fibromyalgia	_____ Migraine headaches
_____ Allergies	_____ GERD (Reflux)	_____ Osteoarthritis
_____ Anemia	_____ Glaucoma	_____ Psychiatric disorder (Other)
_____ Anxiety/panic disorder	_____ Heart murmur	_____ Rheumatic fever
_____ Asthma	_____ Heart trouble	_____ Rheumatoid arthritis
_____ Breathing problems	_____ Hepatitis	_____ Sexually transmitted disease
_____ Chemical dependency	_____ High blood pressure	_____ Sinus problems
_____ Chest pain	_____ Immunosuppressive disorders	_____ Stroke
_____ Chronic cough	_____ Jaundice	_____ Thyroid disorders
_____ Chronic Fatigue Syndrome	_____ Kidney disease	_____ Tuberculosis
_____ Congenital heart lesion	_____ Liver disease	_____ Ulcers
_____ Depression	_____ Low blood pressure	
_____ Diabetes	Other: _____	_____

Family History:

Father: Age, if living_____ His general health _____
Or, age at death _____ Cause of death _____

Mother: Age if living _____ Her general health _____
Or, age at death _____ Cause of death _____

Are there any inherited health conditions or genetic disorders in your family?_____
Please specify _____

Patient's Name_____ Date:_____

Name of Physician:_____ Phone :(___)_____

Address:_____

City:_____ State:_____ Zip:_____

Name of Dentist:_____ Phone :(___)_____

Address:_____

City:_____ State:_____ Zip:_____

Date of last physical exam_____ Date of last dental exam:_____

SLEEP QUESTIONNAIRE

The following questions are helpful in identifying sleep disturbances. This is important in your health history since sleep disorders may be the result or the cause of some pain disorders.

SLEEP HABITS:

1. On weekdays, what time do you usually Go to bed?_____ Get up? _____
2. Average time it takes to fall asleep at night?_____
3. Average time you sleep at night?_____
4. Upon awakening, do you feel refreshed and rested? _____ Yes _____ No
5. Do you have difficulty:
   Falling asleep? _____ Yes _____ No
   Staying asleep? _____ Yes _____ No
6. Are you a restless sleeper? _____ Yes _____ No
7. Do you wake frequently in the night? ___Yes ___ No
   If yes, how many times and what is the cause?
   _____
8. Have you been told that you snore or gasp for breath while sleeping? _____ Yes _____ No
9. Have you ever awakened choking or gasping for breath? ____ Yes _____ No
10. Do you often wake up with morning headaches? _____ Yes _____ No
11. Do you sweat a lot at night without actually being hot?_____ Yes _____ No
12. What is your neck (collar) size (inches)? _____

EXCESSIVE DAYTIME SLEEPINESS:

1. Is daytime sleepiness a problem? _____ Yes _____ No
2. Does sleepiness interfere with your:
   Work? _____ Yes _____ No
   Social Life? _____ Yes _____ No
   Does fatigue interfere with your social life? _____ Yes _____ No
3. Do you often feel tired for no reason? _____ Yes _____ No
4. Are you frequently drowsy or tend to fall asleep while driving?_____ Yes _____ No
5. Have you ever suddenly fallen or experienced sudden bodily weakness when you get really excited, tickled or angry? _____ Yes _____ No
6. When you fall asleep, do you ever see vivid life-like images? _____ Yes _____ No
7. Do you ever awaken and feel that you can't move or that you are paralyzed? _____ Yes _____ No
   If yes, how often?_____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of times for each situation:

Scale

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e., 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 allow	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped in traffic for a few minutes	_____
Total	_____

(See Next Page)

Patient's Name:_____ Date:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You are entitled to a copy of this consent after you sign it.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, the uses and disclosure we may make of your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will post a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dr. Richard J. Polson, the Contact Officer at the above address or at craniopa@swbell.net.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

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).

We can refuse to treat or discontinue treatment if you refuse to sign the Consent for Use and Disclosure of Health Information.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I also consent that any photographs, models, x-rays, MRI's and other testing of me may be used in scientific papers or demonstrations without my identity being revealed. It is understood that any diagnostic and treatment records remain the property of the doctor, but are available for referral. I authorize release of information to Craniofacial Pain Associates, PA and any of its representatives from any past or current health care provider.

The medical/dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at the next visit.

_____ _____

Signature Date

If a personal representative, on behalf of the patient, signs this Consent, complete the following:

_____ _____

Personal Representative's Name Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You May Refuse to Sign this Acknowledgement

I have received and/or read or had read to me a copy of this office's Notice of Privacy Practices.

_____ _____

Signature (Patient, Parent or Personal Representative) Date

Patient's Name:_____ 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.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)_____

RELEASE OF INFORMATION TO FAMILY MEMBERS OF NON-MINOR PATIENT

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you are a non-minor patient depending upon another party (parents or other) for your insurance coverage, financial arrangements or to make appointments for you or if you are requesting that we discuss health information relating to your treatment, payment or healthcare operations with another party such as a family member or personal representative, we require this additional release.

I authorize release of any health information relating to treatment, payment or healthcare operations to

_____

(family member or personal representative) understanding that by signing I agree to hold harmless Craniofacial Pain Associates, PA or any of its representatives in any Privacy Policy action.

_____ _____

Signature Date

PERSONAL INJURY

I have a personal injury suit pending and hereby authorize Craniofacial Pain Associates, PA, or any of its representatives, to release any and all records in its possession including medical/dental, psychological or psychiatric, drug and alcohol, and human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS) to the attorneys representing me and to the worker's compensation insurance company.

My attorney:_____ Contact:_____

Address:_____ Phone :(___)_____

City-State-Zip:_____ Fax :(___)_____

Signature of patient:_____ Date:_____
(Or Parent/Guardian)

INSURANCE AGREEMENT

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with CPA in which the CPA agrees to treat the patient and the patient agrees to pay the CPA's fee for that treatment. The insurance company has no relationship with CPA. If we contact your insurance company and are informed that insurance benefits are available for the treatment recommended, we will file your claim. We are responsible only to file your claim and answer any medical questions they may have.

Insurance companies give estimates and benefits over the telephone, but they are only estimates and are not always accurate nor a guarantee of payment. You will be responsible for your yearly deductible and the portion of the charges your insurance carrier does not cover. We will file your insurance claim within one week of the date services are rendered. You will receive our regular billing as long as your account has a balance. This will keep you informed of the status of your account.

I hereby assign to Craniofacial Pain Associates, PA all of my rights, title and interest to my medical and/or dental reimbursement benefits under my insurance policy with my insurance company. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance company. If the insurance company does not pay their estimated portion within sixty (60) days, I understand the balance is due immediately and agree to pay in full.

_____ _____

Signature of Responsible Party Date