



Dr. Hitesh Patel
Suburban TMJ and Sleep Center
TMJ • FACIAL PAIN • SNORING • SLEEP APNEA
Center of Excellence for TMJ and Sleep

HEAD, NECK, & FACIAL PAIN QUESTIONNAIRE

MR. MRS MISS DR. TODAY'S DATE: _____

NAME: _____

First

Middle Initial

Last

AGE: _____ DATE OF BIRTH: _____ MALE FEMALE

ADDRESS: _____

CITY/STATE: _____

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____ EMAIL: _____

SSN#: _____

MARITAL STATUS: SINGLE MARRIED

DRIVERS LICENSE#: _____ STATE: _____ Copy of

*In accordance with the Federal Trade commission's Red Flag regulations to protect your medical record and identity

EMERGENCY CONTACT PERSON (NAME AND PHONE#): _____

REFERRED BY: _____

DDS MD ENT DC OTHER: _____

REASON FOR THIS APPOINTMENT:

FACE PAIN JAW PAIN EAR PAIN

HEADACHES POPPING CLICKING

FATIGUE/ BREATHING LIMITED OPENING LOCKING

EMPLOYER NAME: _____ PHONE: _____

JOB TITLE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____



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Health Care Practitioners and Patient communication

Please provide us with the name and addresses of all your doctors and healthcare providers

Family Dentist

Providers Name: _____

Street Name/City/State: _____

Orthodontist Oral Surgeon Endodontist

Providers

Name: _____

Street Name/City/State: _____

Family Physician

Providers Name: _____

Street Name/City/State: _____

Specialty Providers

Specialty: _____

Providers Name: _____

Street Name/City/State: _____

Specialty: _____

Providers Name: _____

Street Name/City/State: _____

By signing below, I am giving permission to communicate with the above-named health care providers regarding my treatment

Parent/Guardin Signature: _____ **Date:** _____

Patient Name: _____

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PREVIOUS TREATMENT/ MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication Doctor/Provider Name Approximate Date of Treatment

HEALTH AND MEDICAL HISTORY

Have you ever had prior orthodontic treatments? YES NO

Are you currently pregnant? YES NO

Are you currently breastfeeding? YES NO

SURGICAL HISTORY

Have you ever had your wisdom teeth removed? YES NO

Have you ever had a root canal or any tooth removal for this condition? YES NO

Have you ever had Joint Surgery? YES NO

Have you ever had Orthognathic Surgery? YES NO

Any other type of surgery?

MEDICAL HISTORY

Please check all that apply and leave all others blank. If there is anything not listed indicate the information in the OTHER section

Allergy History

- Allergy Skin Testing
- Allergen Desensitization
- Hay Fever

ENT History

- Adenoidectomy
- Tonsillectomy
- Turbinectomy

Cancer History

- Cancer
- Chemotherapy
- Radiation Therapy

Eye History

- Cataract
- Visual Impairment
- Glaucoma

Pulmonary History

- Asthma
- COPD
- Bronchitis

Infectious Disease

- Measles
- Chicken Pox
- Smallpox
- Diphtheria

Cardiac History

- Congestive Heart Failure
- Heart Attack
- Rhyth Disorder
- Functional Murmur
- Mitral Valve Prolapse
- Angina Pectoris
- Prior MI
- Coronary Artery Disease
- Peripheral Vascular
- Hypertension

Gastrointestinal History

- Hepatitis
- Acute Colitis
- Irritable Bowel Syndrome
- Esophageal Reflux
- Esophageal Ulcer
- Peptic Ulcer
- Chronic Reflux Esophagitis
- Esophagitis
- Esophageal Structure
- Hiatal Hernia

Trauma

- Facial Injury
- Head Injury
- Neck Injury
- Mouth Injury

Hematological History

- Anemia
- Bleeding/Clotting
- Leukemia
- HIV



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Kidney/Bladder History

- Prostate Disorder
- Renal Failure
- Stress Incontinence
- Urinary, Bladder Infections
- Kidney stones
- Urinary Calculus
- Kidney Stones

Endocrine History

- Diabetes
- Thyroid Disorders
- Chronic Fatigue

Neurological History

- Epilepsy
- TIA
- Stroke Syndrome
- Multiple Sclerosis
- Depression
- Bipolar Disorder
- ADHD
- Migraine Headaches
- Vascular Headaches

Musculoskeletal History

- Osteoarthritis
- Arthritis
- Rheumatoid Arthritis
- Osteoporosis
- Fibromyalgia

OTHER HISTORY ITEMS NOT LISTED: _____

Head Pain	Location	Severity			Frequency			Duration				
		Mild	-----	Severe	Month	Weekly	Daily	Second	Minutes	Hours	Days	Weeks
L R B	Front of your head (Frontal)	<input type="checkbox"/>										
L R B	Entire head (Generalized)	<input type="checkbox"/>										
L R B	Top of your head (Parietal)	<input type="checkbox"/>										
L R B	Back of your head (Occipital)	<input type="checkbox"/>										
L R B	In your temple (Temporal)	<input type="checkbox"/>										
Jaw Pain*	Location											
L R B	Jaw pain – on opening											
L R B	Jaw pain – while chewing											
L R B	Jaw pain – at rest											

MOUTH & NOSE RELATED CONDITIONS

- Y N Broken teeth
- Y N Buring tongue
- Y N Chronic sinusttis
- Y N Dry mouth
- Y N Frequent biting of cheek
- Y N Frequent snoring

EAR-RELATED CONDITIONS

- Y N Buzzing in the ears
- Y N Ear congestion
- Y N Ear pain
- Y N Hearing loss
- Y N Pain behind the ear
- Y N Recurrent ear infections
- Y N Tinnitus (ringing in the ear)

JAW SYMPTOMS

- Y N Jaw clicks
- Y N Jaw locks closed
- Y N Jaw locks open
- Y N Jaw popping
- Y N Teeth clenching
- Y N Teeth Grinding

EYE RELATED CONDITIONS

- Y N Blurred vision
- Y N Double vision
- Y N Eye pain
- Y N Pain or pressure behind the eyes
- Y N Photophobia (extreme sensitivity)



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Symptoms – Continued

THROAT, NECK & BACK-RELATED CONDITIONS

Y N Back pain – lower
Y N Back pain – middle
Y N Back pain – upper
Y N Chronic sore throat
Y N Constant feeling of
A foreign object in
Throat

Y N Difficulty in swallowing
Y N Limited movement of the neck
Y N Neck pain
Y N Sciatica
Y N Scoliosis
Y N Shoulder pain
Y N Numbness in the neck, hand or
Fingers

Y N Shoulder stiffness
Y N Swelling of neck
Y N Swollen glands
Y N Thyroid enlargement
Y N Wryneck
Y N Tingling in the hands
or finger

Y N Other: _____

Patient Signature: _____ Date: _____



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MEDICAL HISTORY

TELL US YOUR MEDICAL STORY: _____

When did your condition first occur? _____

What do you believe is the cause of your pain or condition?

- ATHLETIC ENDEAVOR FIGHT FALL ACCIDENT INJURY
 ILLNESS UNKNOWN OTHER: _____

Is there anything that makes your pain or discomfort worst? _____
 (Please describe)

Is there anything that makes your pain and discomfort better? _____
 (Please describe)

What other information is important to your pain or condition? _____

ALLERGIC REACTIONS

Please list all medication and check any substances that have caused an ALLERGIC reaction

- ANESTHETICS IODINE LATEX METALS
 OTHER: _____

CURRENT MEDICATIONS

<u>MEDICATIONS</u>	<u>DOSAGE</u>	<u>REASON FOR TAKING</u>



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Epworth Sleepiness Scale

Patient Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance Of dozing off	1 Sight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public Place (ex theater)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car For an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the Afternoon when circumstances Permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch Without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a Few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE

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Berlin Questionnaire Sleep Evaluation

1. Complete the following

_____ Height _____ Age
_____ weight male female

2. Do you snore?

- yes
 no

If you snore:

3. Your snoring is?

- slightly louder than breathing
 as loud as talking
 louder than talking
 very loud. Can be heard in
Adjacent rooms

4. How often do you snore?

- nearly every day
 3-4 times a week
 1-2 times a week
 never or nearly never

5. Has your snoring ever bothered
Other people?

- yes
 no

6. Has anyone noticed that you quit
Breathing during your sleep?

- nearly every day
 3-4 times a week
 1-2 times a month
 never or nearly never

7. How often do you feel tired or
fatigued after you sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

8. Have you ever nodded off or fallen
asleep while driving a vehicle?

- yes
 no

If yes, how often does it occur?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

9. Do you have high blood pressure?

- yes
 no
 don't know

(FOR OFFICE USE)

Scoring Questions: Any answer within the box outline is a positive response

Scoring Categories: Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive responses and/or a BMI>30

(BMI – Body Mass Index)

Final results: 2 or more possible categories indicates a high likelihood of sleep disordered breathing



Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services and/or co-payments is due at the time services are rendered.

Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for failed appointments and appointments canceled without 24-hour advanced notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not part of that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- 3.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above info` or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient Signature: _____ Date: _____

Hitesh K. Patel D.D.S. D.A.A.P.M., D.A.C.S.D.D., F.I.C.C.M.O., F.A.D.I., F.I.C.D., General Dentist
Diplomate, American Academy of Pain Management, Diplomate, American Academy of Clinical Sleep Disorders Disciplines
Fellow, international. Fellow American College of Dentists. Fellow, International College of Dentists



Notice of Privacy Practices/HIPAA Acknowledgement

The Health Insurance Portability and Accountability act of 1996 (HIPAA), established Privacy Rule to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for the uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information regarding treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

We may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Be sure to review the Notice of Privacy Practices for important information about your rights under HIPAA.

By signing below, you acknowledge that the Notice of Privacy Practices was made available for your review if you request it, you had the opportunity to request a copy for yourself and may view the document on your website.

Signature: _____ Date: _____

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CPAP INTOLERANCE AFFIRMATION SHEET

Patient Name:

I, make my statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts, and things set forth are true and correct to the best of my knowledge.

I have been prescribed the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis due to the following reason (s):

- Mask Leaks
- Mask is uncomfortable / device is uncomfortable
- Unable to sleep comfortably
- Noise disturbs sleep and / or bed partners sleep
- Movement is restricted during sleep
- Does not seem to be effective
- Straps/ Headgear cause discomfort
- Pressure in the upper lip caused tooth related problems
- Latex allergy
- Claustrophobia
- Other

Because of my intolerance / inability to use the CPAP, I wish to have an alternative method of treatment. The method of treatment is an Oral Airway Dilator Appliance, as prescribed to me by:

Dr.

Patient Signature

Witness Signature

Date: