Craniofacial Pain & Dental Sleep
Center of Georgia

678.899.6076
678.899.6075
www.cpcgeorgia.com
office@cpcgeorgia.com

HEADACHES ■ FACIAL PAIN ■ NECK PAIN ■ TMJ DISORDERS ■ SLEEP APNEA

○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Other

First Name _____ Middle Initial _____ Last Name _____

Responsible Party: (If Someone Other than Patient) Name _____

Who is primary on Insurance: ○ Self ○ Spouse ○ Father ○ Mother Name _____

Date of Birth _____

Patient Information

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Date of Birth: _____ Age: _____ Social Security Number: _____

Spouse Name: _____ Date of Birth: _____

E-Mail: _____@_____

○ Employed Student Status: ○ Full Time ○ Part Time

Family Dentist: _____ Dentist's Phone: _____

Family Physician: _____ Physician's Phone: _____

Referred By: _____ Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

ALLERGENS

☐ No known allergens	☐ Iodine	☐ Plastic	☐ Antibiotics
☐ Latex	☐ Sedatives	☐ Aspirin	☐ Local anesthetics
☐ Sleeping pills	☐ Barbiturates	☐ Metals	☐ Sulfa drugs
☐ Codeine	☐ Penicillin		

Other _____

CURRENT MEDICATIONS

Medicine	Dosage/Frequency	Reason

OFFICE USE ONLY

I verify that I obtained a copy of the patient's photo ID and insurance card and made a copy of each for our records. Initial _____, Date _____

MEDICAL HISTORY (CONT'D)

Medical Condition	Never	Current	Past	Date/Note	Medical Condition	Never	Current	Past	Date/ Note
Acid reflux	☐	☐	☐	_____	Hepatitis	☐	☐	☐	_____
Anxiety	☐	☐	☐	_____	Hypoglycemia	☐	☐	☐	_____
Anemia	☐	☐	☐	_____	Immune system disorder	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____	Insomnia	☐	☐	☐	_____
Atherosclerosis	☐	☐	☐	_____	Ischemic heart disease (reduced blood supply)	☐	☐	☐	_____
Asthma	☐	☐	☐	_____	Kidney Problems	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____	Liver disease	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____	Meniere's disease	☐	☐	☐	_____
Blood pressure – High	☐	☐	☐	_____	Mitral valve prolapsed	☐	☐	☐	_____
Blood pressure – Low	☐	☐	☐	_____	Mood disorder	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____	Multiple sclerosis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____	Muscular dystrophy	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____	Nasal allergies	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____	Neuralgia	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____	Osteoarthritis	☐	☐	☐	_____
COPD	☐	☐	☐	_____	Osteoporosis	☐	☐	☐	_____
Coronary heart disease	☐	☐	☐	_____	Parkinson's disease	☐	☐	☐	_____
Current pregnancy	☐	☐	☐	_____	Prior orthodontic treatment	☐	☐	☐	_____
Depression	☐	☐	☐	_____	Psychiatric care	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____	Radiation treatment	☐	☐	☐	_____
Difficulty Sleeping	☐	☐	☐	_____	Rheumatic fever	☐	☐	☐	_____
Dizziness	☐	☐	☐	_____	Rheumatoid arthritis	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____	Sinus problems	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____	Sleep apnea	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____	Stroke	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	Tendency for ear infections	☐	☐	☐	_____
Gout	☐	☐	☐	_____	Thyroid disorder	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____	Tuberculosis	☐	☐	☐	_____
Heart murmur	☐	☐	☐	_____	Tumors	☐	☐	☐	_____
Heart pacemaker	☐	☐	☐	_____	Urinary disorder	☐	☐	☐	_____
Heart valve replacement	☐	☐	☐	_____	Wisdom teeth extraction	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____	_____		☐	☐	_____
_____		☐	☐	_____	_____		☐	☐	_____
_____		☐	☐	_____	_____		☐	☐	_____
_____		☐	☐	_____	_____		☐	☐	_____
_____		☐	☐	_____	_____		☐	☐	_____

SURGICAL OPERATIONS

☐ Adenoids ☐ Heart ☐ Neck ☐ Appendectomy ☐ Hernia repair
☐ Periodontal ☐ Back ☐ Jaw joint ☐ Thyroid ☐ Ear
☐ Lung ☐ Tonsillectomy ☐ Gallbladder ☐ Nasal ☐ Uvulectomy (UPPP)

Other _____

FAMILY HISTORY

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Stroke ☐ Father snores ☐ Heart disease ☐ Sleep disorder
☐ Mother snores ☐ Diabetes ☐ Obesity ☐ Father has sleep apnea ☐ High blood pressure
☐ Thyroid disorder ☐ Mother has sleep apnea

Other _____

SOCIAL HISTORY

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes: ◯ Never Smoked ◯ Current Smoker ◯ Quit
# of pack per day _____ When did you quit?
# of years _____ _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ◯ Yes ◯ No If yes, # of drinks per week: _____

Caffeine Intake: ◯ None ◯ Coffee/Tea/Soda # of cups per day _____

Regular exercise: ◯ Yes ◯ No

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please <u>number</u> the complaints with #1 being the most important.

____ Frequent heavy snoring
____ which affects the sleep of others
____ Significant daytime drowsiness
____ I have been told that "I stop breathing" when sleeping.
____ Difficulty falling asleep
____ Gasping when waking up
____ Nighttime choking spells
____ Feeling unrefreshed in the morning

____ Morning hoarseness
____ Morning headaches
____ Swelling in ankles or feet
____ Nocturnal teeth grinding
____ Jaw pain
____ Facial pain
____ Jaw clicking

Other: _____ _____

NAME: _____ DATE:_____

EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 for each situation:

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

SITUATION	0	1	2	3
Sitting and reading				
Watching TV				
Sitting inactive in a public place (theatre, 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 the traffic				

Total: _____

Screening Tool for Sleep Apnea - Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring

a). Do you snore on most nights (> 3 nights per week)?

Yes (2) No (0) _____

b). Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a). You are busy or active?

Yes (2) No (0) _____

b). You are driving or stopped at a light? _____

Yes (2) No (0) _____

5) Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

Total: _____

Score: **9 points or more** – refer to sleep specialist or order sleep study
6-8 points – gray area use clinical judgement
5 points or less – low probability of sleep apnea

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

If Yes:

Sleep Center Name and Location _____

_____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evalution confirmed a diagnosis of: ☐ *mild* ☐ *moderate* ☐ *severe* obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- ☐ mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ discomfort caused by the straps and headgear
- ☐ disturbed or interrupted sleep caused by the presence of the device
- ☐ noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ pressure on the upper lip causing tooth related problems
- ☐ a latex allergy
- ☐ claustrophobic associations
- ☐ an unconscious need to remove the CPAP apparatus at night

Other: _____ _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

Patient Signature _____ Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

category 1

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slighly 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
- ☐ 1-2 times a month
- ☐ 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 week
- ☐ 1-2 times a month
- ☐ never or nearly never

category 2

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

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

8. During your waketime, do you feel tired, fatigued or not up to par?

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

9. 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

category 3

10. 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 response and/or a BMI>30 ☐

BMI = (Body Mass Index)

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

Patient Signature _____ Date _____

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CRANIOFACIAL PAIN CENTER OF GEORGIA, P.C.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED 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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 (including 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 absence or incapacity or in 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 healthcare. 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, xrays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who

may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page, $ 30 per hour for staff time to 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 your health information for a fee. Contact us using the information listed at the end of this Notice for a full 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 accounting more than once in 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions 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. We will provide you with the address to file your complaint with 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: Mayoor Patel, D.D.S., M.S. Telephone: 678 899 6076 Fax: 678 899 6075
E-mail: office@cpcgeorgia.com Address: 200 Ashford Center North, Suite 195. Atlanta, GA 30338

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Acknowledgement of Receipt of Notice of Privacy Practices

CRANIOFACIAL PAIN CENTER OF GEORGIA, P.C.
Acknowledgement of Receipt of
Notice of Privacy Practices

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

Print Name _____

Signature _____ Date _____

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable medical/dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Used or Disclosed: Medical and Dental health history, Clinical & Imaging study Findings, Treatment plan, Progress report and Completion of treatment.

Purpose for Disclosure: To keep your health care provides informed of your treatment.

I authorize the following person(s) to make the requested use or disclosure of the above health information: Doctor and Staff at Craniofacial Pain Center of Georgia P.C.

Person(s) Receiving My Authorized Information Include (Fill in names):

Medical Doctor: _____ Dentist: _____

Referring Doctor: _____ Insurance Company: _____

Other: _____

I understand that I may revoke this authorization at any time by notifying Craniofacial Pain Center of Georgia, P.C. in writing. If I choose to do so, my revocation will not affect any actions taken by Craniofacial Pain Center of Georgia, P.C. before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This Authorization Expires on ☐ Continue Indefinitely ☐ Effective Only Until _____ (date).

Signature of Patient or Patient's Personal Representative

_____ Date _____

If Personal Representative: Print Name _____

Signature _____ Relationship to Patient _____

For office use only: Copy of signed authorization provided to the individual: Date: _____ Initials _____.

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INSURANCE POLICY

The Craniofacial Pain Center of Georgia does not file or accept assignment from medical insurance companies, due to many reasons such as: inconsistencies in benefit information, extreme delays in payment, multiple denials of a claim for no legitimate reasons, do not pay directly to our office since we are not a network provider.

We need to inform you that you are entering into a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fees for that treatment. The insurance company has NO relationship with the doctor.

As a courtesy to you, we will prepare two copies of a paid invoice form and any supporting documentation that we feel the insurance company may need for each visit with us for which there is a charge. Always keep one copy for your records.

Any additional information needed to process your claims will be provided upon request from the insurance company.

We suggest to all patients that they contact their insurance company to find out their TMJ/Apnea benefits, policies and limitations. Remember, insurance companies give estimates and benefits over the phone, however they are ONLY estimates and are not always accurate or a guarantee of reimbursement.

FINANCIAL POLICY

Fees are paid as services are rendered. We accept all major credit cards, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and or CASH.

Payment plans for the estimated treatment may be made with Care Credit Services upon prior approval of your credit application. Several payment options, (with and without interest) are offered.

I will pay for services rendered on the date of service. I acknowledge that I have read this form and that I fully understand its contents that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily.

THIS IS NOT A CONTRACT NOR AN AGREEMENT TO SEEK TREATMENT

Signature of patient:_____ Date: _____/_____/_____
(Parent or guardian)