HEAD PAIN INSTITUTE

Patient Information and Health Questionnaire

☐ MR. ☐ MS. ☐MISS ☐ MRS. ☐ DR. **TODAY'S DATE:** _____

PATIENT NAME: _____
First Middle Initial Last

AGE: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

ADDRESS: _____ **CITY/STATE/ZIP:** _____

CELL PHONE: _____ **HOME PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____

SS#: _____ **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED

DRIVERS LICENSE #/STATE_____ ☐ **Copy of Drivers License***
*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** ☐ **HEADACHES** ☐ **FATIGUE/BREATHING CONCERNS** ☐ **OTHER:** _____

EMPLOYER NAME: _____ **PHONE:** _____

ADDRESS: _____ CITY/STATE/ZIP: _____

JOB TITLE: _____

PAYMENT TYPE: ☐ **INSURANCE** ☐ **SELF-PAY** ☐ **AUTO** ☐ **WORKERS COMP.**

HEALTH INSURANCE NAME: _____**POLICY/GROUP #:**_____

☐ **Copy of health insurance card***
*In accordance with the Federal Trade Commission's Red Flag regulations to protect your medical record and identity

PRIMARY INSURED NAME/DATE OF BIRTH: _____

RELATIONSHIP TO PRIMARY INSURED: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER:_____

WORKERS COMP.: INSURANCE NAME: _____

CASE MANAGER NAME AND CONTACT #: _____

CLAIM #: _____ **DATE OF INJURY:** _____

AUTO: DATE OF ACCIDENT: _____

ATTORNEY AND/OR AUTO INSURANCE NAME: _____

ADDRESS: _____

PHONE #: _____ **POLICY #:** _____

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WHAT ARE YOUR 3 CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
Please mark only 3 main complaints then rate your complaints for **intensity** on a scale of 0-10 with 0 being none and 10 being the worst.

- ☐_____Jaw Pain
- ☐_____Headache Pain
- ☐_____Facial Pain
- ☐_____Throat Pain
- ☐_____Tooth grinding
- ☐_____Jaw Joint Locking
- ☐_____Dizziness
- ☐_____Kicking and jerking leg repeatedly
- ☐_____Fatigue
- ☐_____Repeated awakening
- ☐_____Significant daytime drowsiness
- ☐_____Told that "I stop breathing" during sleep
- ☐_____Ear Pain
- ☐_____Pain when chewing
- ☐_____Eye Pain
- ☐_____Neck Pain
- ☐_____Limited ability to open mouth
- ☐_____Jaw Joint Noises
- ☐_____Tinnitus (ringing in the ears)
- ☐_____Dry Mouth when waking
- ☐_____Difficulty falling asleep
- ☐_____Feeling unrefreshed in the morning
- ☐_____Frequent heavy snoring
- ☐_____Unable to tolerate C-Pap

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?

Pick One:

☐AUTO ACCIDENT ☐MOTORCYCLE ACCIDENT ☐WORK RELATED ACCIDENT

☐ATHLETIC ENDEAVOR ☐FIGHT ☐FALL ☐ACCIDENT ☐ILLNESS ☐INJURY

☐UNKNOWN ☐OTHER:_____

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

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

What other information is important to your pain or condition? _____
(Please describe)

ALLERGIC REACTIONS

Please list all medications and check or list the substances that have caused an ALLERGIC REACTION

☐ANESTHETICS ☐IODINE ☐LATEX ☐METALS ☐Other: _____

☐Other: _____ ☐Other: _____ ☐Other: _____

CURRENT MEDICATIONS ☐ Patient medication list attached

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for taking

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PREVIOUS TREATMENTS/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 had your wisdom teeth removed? ☐YES ☐NO

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

Have you ever had Jaw Joint Surgery? ☐YES ☐NO

Have you ever had Orthognathic Surgery? ☐YES ☐NO

Any other types of surgery? _____

_____

MEDICAL HISTORY

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

Allergy History
- ☐ Allergy Skin Testing
- ☐ Allergen Desensitization
- ☐ Hay Fever

Eye History
- ☐ Cataract
- ☐ Visual Impairment
- ☐ Glaucoma

Cardiac History
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rhythm Disorder
- ☐ Functional Murmur
- ☐ Mitral Valve Prolaspe
- ☐ Angina Pectoris
- ☐ Prior MI
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular
- ☐ Hypertension

ENT History
- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Turbinectomy

Pulmonary History
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Gastrointestinal History
- ☐ Hepatitis
- ☐ Acute Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Esophageal Reflux
- ☐ Esophageal Ulcer
- ☐ Peptic Ulcer
- ☐ Chronic Reflux Esphagitis
- ☐ Esophagitis
- ☐ Esophageal Stricture
- ☐ Hiatal Hernia

Cancer History
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy

Infectious Disease
- ☐ Measles
- ☐ Chicken Pox
- ☐ Smallpox
- ☐ Diphtheria

Trauma
- ☐ Facial Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Mouth Injury

Hematological History

Anemia
Bleeding/Clotting
Leukemia
HIV

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MEDICAL HISTORY Cont.
Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Kidney/Bladder History
- ☐ Prostate Disorders
- ☐ Renal Failure
- ☐ Stress Incontinence
- ☐ Urinary, Bladder Infections
- ☐ Kidney Stones
- ☐ Urinary Calculus

Endocrine History
- ☐ Diabetes Mellitus
- ☐ 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: _____

CURRENT SYMPTOMS

Systemic symptoms
- ☐ Feeling tired or poorly
- ☐ Weight change
- ☐ Chills
- ☐ Fever

Otolaryngial Symptoms
- ☐ Mouth sores
- ☐ Difficulty swallowing (dysphagia)
- ☐ Difficulty chewing
- ☐ Dentures currently being worn
- ☐ Dentures improperly fitting

Head symptoms
- ☐ Headache
- ☐ Facial pain
- ☐ Sinus pain
- ☐ Tooth pain

Musculoskeletal symptom
- ☐ Joint pain, localized in the jaw (joint)
- ☐ Diffuse joint pains (arthralgias)
- ☐ Joint pain, localized
- ☐ Joint swelling, localized
- ☐ Muscle aches
- ☐ Muscle cramps
- ☐ Legs feel restless
- ☐ Other

Neck symptoms
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Lump or swelling

Gastrointestinal
- ☐ Appetite
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Regurgitation
- ☐ Yellow skin/eyes (jaundice)
- ☐ Inability to pass gas
- ☐ Bowel movement frequency
- ☐ Diarrhea
- ☐ Unable to control passing gas
- ☐ Constipation
- ☐ Rectal Pain

Neurological symptoms
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting (syncope)
- ☐ Motor disturbances
- ☐ Sensory disturbances
- ☐ Decreased concentrating ability

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Slow heart rate
- ☐ Leg pain with exercise
- ☐ Cold hands/feet

Endocrine
- ☐ Temperature intolerance
- ☐ Excessive sweating
- ☐ Hot flashes
- ☐ Muscle weakness
- ☐ Muscle weakness
- ☐ Sexual complaints
- ☐ Changes in body proportion
- ☐ Hair symptoms

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CURRENT SYMPTOMS Cont. Please check all that apply and leave all others blank

Psychological symptoms
- ☐ Mood
- ☐ Energy level
- ☐ Behavior
- ☐ Sleep disturbances
- ☐ Neurological symptoms

Skin symptoms
- ☐ Pruritus
- ☐ Skin Lesions
- ☐ Rashes

OTHER SYMPTOMS NOT LISTED: _____

_____

HEAD PAIN

If you have different levels of headaches, the below refers to the worst headache as opposed to a daily tension-type headache.

Location *L=Left R=Right B=Both*	*Recent*	*Chronic* *Over 6 months*	*Severity* *Mild*	*Mod*	*Severe*	*Duration* *Min.*	*Hrs.*	*Days*	*Frequency* *Occasional*	*Frequent*	*Constant*
L☐ R☐ B☐ Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Parietal (Top of Head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Occipital (Back of Head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Temporal (Temple Area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please check the appropriate boxes, if applicable.

JAW PAIN
- L☐ R☐ Jaw Pain when opening
- L☐ R☐ Jaw Pain when chewing
- L☐ R☐ Jaw Pain at rest

JAW JOINT SOUNDS (Clicking, Crunching, Popping)
- L☐ R☐ Jaw Sounds when opening
- L☐ R☐ Jaw Sounds when chewing
- L☐ R☐ Jaw Sounds at rest

JAW LOCKING
- Yes☐ No☐ Jaw Locks Closed
- Yes☐ No☐ Jaw Locks Open

JAW JOINT SYMPTOMS
- Yes☐ No☐ Teeth Clenching Day☐ Night☐
- Yes☐ No☐ Teeth Grinding Day☐ Night☐

EYE RELATED CONDITIONS
- Yes☐ No☐ Blurred Vision
- Yes☐ No☐ Double Vision
- Yes☐ No☐ Eye Pain
- Yes☐ No☐ Pain or pressure behind the eyes
- Yes☐ No☐ Extreme Sensitivity to light
- Yes☐ No☐ Wear Glasses or Contacts

EAR RELATED CONDITIONS
- L☐ R☐ Buzzing in the ears
- L☐ R☐ Ear congestion
- L☐ R☐ Ear pain
- L☐ R☐ Hearing Loss
- L☐ R☐ Itching or stuffiness in the ears
- L☐ R☐ Pain behind the ear
- L☐ R☐ Pain in front of the ear
- L☐ R☐ Recurrent ear infections
- L☐ R☐ Ringing in the ear (Tinnitus)

MOUTH AND NOSE RELATED CONDITIONS
- Yes☐ No☐ Dry Mouth
- Yes☐ No☐ Chronic sinusitis
- Yes☐ No☐ Frequent snoring
- Yes☐ No☐ Burning tongue
- Yes☐ No☐ Broken teeth
- Yes☐ No☐ Frequent biting of the cheek

SLEEP CONDITIONS Please select yes or no answers on your average sleep experience and/or what a sleep partner has told you

Sleep Positions Side☐ Back☐ Stomach☐ Varies☐

Is it easy to fall asleep? Yes☐ No☐

Do you feel rested upon AM waking? Yes☐ No☐

Stopped breathing during sleep? Yes☐ No☐

Average hours of sleep per night _____

Do you wake often during the night? Yes☐ No☐

Gasping or Choking during sleep? Yes☐ No☐

Have you ever had a Sleep Study (PSG)? Yes☐ No☐

Result was:_____

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Family History
- ◻ Diabetes Mellitus
- ◻ Cancer
- ◻ Loss of Hearing
- ◻ Allergies
- ◻ Stroke
- ◻ Hypertension
- ◻ Asthma
- ◻ Heart Disease
- ◻ CAD – Coronary artery disease
- ◻ CHF – congestive heart failure
- ◻ Pulmonary Hypertension
- ◻ PVD – peripheral vascular disease
- ◻ Migraine Headache
- ◻ Cluster Headache
- ◻ Meniere's Disease
- ◻ Neurofibromatosis Type 1 (Recklinghausen's Disease)

Social History
- ◻ Life circumstance event
- ◻ Caffeine use
- ◻ Tobacco use
- ◻ Smoking cigarettes
- ◻ Alcohol
- ◻ Drug use
- ◻ Marijuana use
- ◻ Occupation _____

By signing below, I authorize the release of all examination findings and diagnosis, report and treatment plans, etc. to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all chargers incurred for my treatment regardless of insurance coverage.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINTED PATIENT NAME: _____

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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	1 Slight chance of dozing	2 Moderate Chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in public place (ex. theater)	☐	☐	☐	☐
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: _____

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Health Care Practitioners and Patient Communication

Please provide us the names and addresses of all your doctors and health care 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: _____

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.

Patient/Guardian Signature:_____ Date:_____

Printed Patient Name: _____

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HEAD PAIN INSTITUTE

Consent for Care

I agree to be evaluated and treated at the Head pain Institute, (herein after referred to as The Practice) by a Practice Provider as deemed medically appropriate. I acknowledge that no procedure will be performed without having been provided appropriate information regarding treatment and possible side effects or consequences. Signing this document implies informed consent on the part of the patient. In this arena, the Practice is released from harm. Although the physician and staff will make efforts to obtain my appropriate medical history and information, the Practice shall not be held responsible for issues of omission or negligence on the part of the patient.

I further acknowledge that the Practice is not functioning as my primary care/family physician, and if there are issues dealing with my primary care or internal medicine, they may be referred to my primary care physician by the Practice. There may also be instances where the Physician of the Practice will refer me to additional specialty care and evaluation as needed.

As for my responsibility to the Practice, I agree to attend appointments and therapies as scheduled. Multiple missed appointments, or inappropriate behavior may result in termination of services and referral to their physicians. Failure to cancel or no show for appointments will be subject to a charge for that visit.

During your therapy, it may become necessary to discuss surgical treatment options if painful or restrictive joint function continues. This may include arthroscopic or open TMJ surgery and/or possible jaw repositioning surgery. A Practice Provider will, if necessary, discuss these options thoroughly. Following initial appliance therapy, there may be decisions to make by the patient and doctor concerning stabilizing or correcting the bite at the natural jaw position, determined by your muscles, if necessary. As joints and muscles relax and heal, there will be changes in your bite (how your teeth come together). Once, it is felt that you have reached your optimum level of improvement, adjusting your bite to your new jaw position may be recommended.

As part of your care, you may receive injections of one kind or another. Usually, these are trigger point injections into the motor point of various painful muscles. On occasion, a joint injection will be done. This consent for treatment acknowledges that there can be side effects from any injection. Side effects can include: allergic reactions, localized pain at the injection site or pain along the referral pattern of the nerve or muscle injected. On rare occasions more serious adverse events have been known to occur: fever, infection, muscle and bone atrophy, rash anaphylaxis, pneumothorax, breathing difficulty, sudden changes in blood pressure, convulsions, death.

If a procedure is going to be done, a further discussion will ensue, but you are encouraged to ask questions. We wish to empower you to seek a higher level of health by getting involved. Help us to understand you.
Headache, TMJ disorders and sleep apnea are chronic conditions that are managed, not cured, we are not able to guarantee that all patient's condition will improve. Upon rare occasion, condition and symptoms may worsen.

No intra-oral exam will be performed. We will not be examining your teeth or oral cavity, even though we will be looking in your mouth for other issues. Additionally, we will not be taking x-rays of your teeth. It is your responsibility to have a general dentist examine and maintain your oral health. If you do not have a general dentist, we may be able to recommend one.

Imaging (CTor MRI) may be required to have imaging of the head and neck performed for diagnostic and treatment purposes. Ultrasound and ICAT units are available on premises or a referral to an imaging center will be made.

A Practice Provider may at times refer patients to Lab Express for lab work or to AZPMR for evaluation & treatment: both facilities are owned and operated by family members of one of the Practice Providers. Practice Providers do not have ownership, any financial interests nor does they receive any monetary compensation from either of the above entities.

At random times at the doctor's discretion our patients may be asked to provide a specimen for screening. This is intended to understand what chemical factors are contributing to your symptoms. An inquiry to the State Pharmacy Board may also be performed when indicated.

Signature: _____ **Date:** _____

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Financial Policy

General
Please be informed that your Insurance Company may not pay for all treatment. We cannot guarantee what services or items will be covered by your insurance. If your Insurance Company does not pay for the services, or items provided, you will be responsible for payment in full. Some services may not be covered by your plan or may not be considered medically necessary. It is your responsibility to check your in-network and out-of-network insurance benefits which can vary widely among insurance plans. If you have not met your deductible, it may be collected at the time of service. If you wish to self-pay for services, please discuss this option with a Head Pain Institute representative.

If the Head Pain Institute® (AZ TMJ, PLLC) is out-of-network with your Insurance Company, you will be responsible to bring us all correspondence from the Insurance Company and sign over any insurance checks sent directly to you or make payment directly to the Head Pain Institute.

Non-Insurance Patients
All payments are to be made at the time of service. The Head Pain Institute accepts cash, check, and credit cards. We also offer the option of financing your treatment. If you wish to bill an insurance company any time during or after treatment for reimbursement, we can provide you with the necessary forms upon request. If you have Medicare, they will not allow you to submit a claim for reimbursement.

All Patients
Appointment times are valuable, and many patients have to wait several weeks to get in. That is why it is important for you to make sure you are at your scheduled appointment. A minimum $100.00 fee will be charged for missed appointments without 24-hour advance notice.

A $35.00 fee will be charged for any checks returned for insufficient funds. Any amounts that are 90-days past due may go to collections and you agree to be responsible for legal fees (court, attorney, process server, etc.), collection agency fees, interest charges (2% per month) and any other expenses incurred in the collection of your debt.

If an appliance is not accepted and received by the patient for any reason, the patient will be responsible to pay a $500.00 fabrication fee for each appliance.

If treatment is rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the amount due.

I understand that all fees paid are for services-rendered-fees are not refundable and are not based on the result of treatment. By signing below, you understand and agree to the terms of this Financial Policy:

Signature: _____ **Date:** _____

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Notice of Privacy Practices/HIPAA Acknowledgement

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

As our patient, 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 health care information regarding treatment, payment or health care operations, in order to provide health care 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 health care operations. These entities are most often not required to obtain patient consent.

You 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 practice 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 our website.

Signature: _____ **Date**: _____

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Phone: (480) 945.3629 Fax (480) 664.8972

Patient Full Name (*Print*): _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for the services or items listed below, you may have to pay. Our insurance will not guarantee payment. Some services may not be covered by your plan or may be considered medically necessary. The insurance company on their own determines what is medically necessary without examining or interviewing the patients and frequently this decision is made by a non-physician. Insurance companies are finding more clever ways of denying claims. We expect your insurance may not pay for the services or items listed below.

Services or Items:	Reason your insurance company may not pay:	Estimated Cost
• Exams or treatment for Temporomandibular disease • Injections • Splints (1 or 2) CPT's 21085, S8262, E0486 • Radiology Services • Botox Injections • PRP Injections • Supartz Injections • Splints (1 or 2) Remake	They may not feel your treatment is medically necessary and you should be able to manage on your own, or their policies are such that they will only cover surgery	$400-$5,700

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may feel after you finish reading.
- Choose an option below about whether to receive the services or items listed above.

OPTION: Check only one box and initial. We cannot choose a box for you.

☐ OPTION 1. I want the services and items listed above. I agree to pay all deductible, co-pays, and known uninsured procedures in advance. I understand that if my insurance doesn't pay, I am responsible for all services not covered or denied, including those deemed not medically necessary. If my insurance does not pay for my procedures within ninety (90) days from the date of service, I will be responsible for the total balance on my account. I understand amounts billed are higher amounts and adjustments are generally made as per my insurance company's fee schedule. Initial _____

☐ OPTION 2. I want the services and items listed above, but do not bill my insurance. I am waiving my rights to bill my insurance carrier(s). You may ask to be paid now as I am responsible for full payment.
_____Initial

☐ OPTION 3. I don't want the services and items listed above._____Initial

Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call the number on the back of your insurance card and speak with a customer services representative. You can always petition your insurance's decision, but you are responsible for any payment upfront. If payment is awarded, we will refund any amounts due.

Signing below means that you have received and understand this notice. You also received a copy.

Signature:	Date:

HEAD PAIN INSTITUTE

New Patient Health Assessment

PATIENT NAME: _____ **AGE:** _____ **DATE:** _____

What are your three chief complaints?

1. _____

2. _____

3. _____

Circle any symptoms that you are experiencing or have experienced that we need to be aware of for your visit today.

Cardiology

Palpitations Heart Rate Leg Pain Chest pain

Cold Extremities

Dermatology

Dry or Sensitive Skin Hives Rash

Ears/Nose/Throat

Mouth Sores Difficulty Swallowing

Difficulty Chewing Wear Dentures

Tongue Burning Mouth Burning Tooth Pain

Sinus Pain Snoring Change in Voice

Ear Pain Hearing Loss Ringing in Ears

Sore Throat

Musculoskeletal

Neck pain Neck Lump/Swelling Jaw Pain

Muscle Cramps Neck Stiffness Restless Legs

Joint Pain Joint Swelling

Respiratory

Gasping for Air While Sleeping Cough

Stop Breathing While Sleeping Chest Pain

Shortness of Breath Wheezing

Constitutional

Fatigue Fever Weight Gain Weight Loss

Endocrinology

Hot Flashes Hair Symptoms Cold Tolerance

Excessive Sweat Excessive Thirst Excessive Urination

Fatigue Heat Tolerance Sleep Disturbance

Gastroenterology

Appetite Normal Excessive Gas

Abdominal Pain Blood in Stool Vomiting

Constipation Diarrhea Difficulty Swallowing

Heartburn Nausea

Neurology

Facial Pain Dizziness Fainting (Syncope)

Headache Sensory Disturbances

Decreased Concentration Ability Vertigo

Psychology

Energy Level Change Receiving Counseling

Eating Disorder High Stress

Serious Depression Sleep Disturbances

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