

PATIENT INFORMATION

Patient Name: _____
Last Name First Name Initial
Mailing Address _____ Home Phone: _____
City: _____ State: _____ Zip _____ Cell Phone _____
Street Address (if different) _____
Sex: ___ M ___ F Age: _____ Birth date: ___/___/____ Social Security# _____
Employer: _____ Occupation _____ Business Phone : _____
Spouse or parent name: _____ SSN# _____ Birth date ___/___/____
In case of emergency notify: _____ Relationship _____ Phone _____

Kindly give a 48 hour notification of canceling an appointment. If you miss your appointment completely a fee may be applied to your account.

INSURANCE INFORMATION

We have opted out of Medicare/Medicaid and we are out of network for all insurances. In most cases and as a courtesy, we can assist the patient in billing claims to the insurance company. This office cannot guarantee that the insurance company will reimburse patient for services received at this office. In the event an insurance check was sent to our office, a refund will be issued to the patient. However, if there is a balance owed on the patient's account, assignment of benefits will be made to the provider and any insurance check(s) received will be applied towards the patient's outstanding ledger.

With the exception of workers compensation claims, the patient is responsible for verifying benefits, obtaining referrals or obtaining prior authorizations/certification. Please note, the Craniofacial Pain and Sleep Center will do all that is possible to get the patient reimbursed by filing with the carrier(s) applicable on behalf of the patient.. Unless prior arrangements are made, payment is due at time of service and acceptable forms of payment are: Cash, Check, Money Order, all major Credit Cards and CitiHeath Financing.

Insurance Company: _____ Phone# _____
Billing Address: _____ City: _____ State: ___ Zip: _____
Type of policy (Please Circle) Dental Health Worker's Comp Auto Date of Accident _____
Member ID/ Claim# _____ Group# _____ Adjuster's Name _____
Policy Holder's Name: _____ SSN _____ Birth Date _____

Secondary insurance is the members' responsibility to file

ASSIGNMENT/ RELEASE/ CONSENT

I certify that I (or my dependent) have insurance coverage with the above named company. I understand that, unless prior arrangements have been made, payment of insurance benefits will be directed to myself or policy holder (workers comp and MVA excepted). I hereby authorize the doctor to release all information necessary to secure payment of benefits and I authorize the use of this signature on all insurance submissions. CDC cannot bill your insurance without the appropriate signature below.

I am requesting and consenting to the diagnostic and therapeutic procedures to be performed by Craniofacial Pain and Sleep Center, Dr. Richard Keller or staff.

I hereby warrant that I have not been legally adjudged as incompetent. I understand that it is my right to determine the extent of my medical/dental care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test procedure, or therapy performed by Craniofacial Pain and Sleep Center physicians and/or staff.

X _____
Signature Date

Patient Name _____ **Date** _____

HISTORY QUESTIONNAIRE

Please check any of the following conditions you now have or have had in the past

- | | | |
|--------------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis A B or C | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Creutzfeldt- Jakob Dis. | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers - gastric |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood pressure | _____ |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Malignancies | _____ |

1. Are you presently taking any medications? Please list _____ YES NO

2. Are you allergic to any medications or latex? Please list _____ YES NO

3. Are you pregnant? YES NO Are you taking birth control pills? YES NO
4. Do you smoke or chew tobacco? If yes, how much/week _____ YES NO
5. Do you drink alcohol? If yes, how much/week _____ YES NO
6. What is your **chief** complaint? _____

7. When did this begin? _____
8. Was this the result of an accident, fall or blow of any kind? YES NO
 Please explain _____
9. Please list **all** automobile accidents you have been involved in. Give dates, and a description of each occurrence. Indicate if you were the driver or passenger, if you wore a seatbelt or if you hit your head.

Date	Driver or passenger	Seat Belt	Description
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10. Have you ever received a blow to the face/head in any other type of accident or assault? If yes please describe.

Date	Description	YES NO
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11. Do you have problems with headaches? If yes, since when _____ YES NO
 What is their intensity? Mild Moderate Severe
 How frequent are they? Constant _____
 Daily _____ # of times per day _____
 Weekly _____ # of times per week _____
 Monthly _____ # of times per month
12. If there is a particular time of day/night that your headaches seem to occur or are intense, please describe.

13. Please describe any and all areas of your head where your headaches occur (i.e. top, temples, forehead, etc)

14. During your headaches, do you have sensitivity to light? YES NO
15. Do you have neck pain? YES NO
16. Do you have shoulder pain? ___ Right ___ Left YES NO
17. Do you have any back pain? ___ Upper ___ Mid ___ Low YES NO
18. Do you have ear pain? ___ Right ___ Left YES NO
19. Do you have any ear congestion or plugged ears? ___ Right ___ Left YES NO
20. Do you have ringing or buzzing noises in your ears? ___ Right ___ Left YES NO
 If yes, are the noises: ___ Constant ___ Intermittent
21. Do you have a problem with dizziness? YES NO
22. Do you find it difficult to swallow food or liquid? YES NO
23. Do you have a problem with throat pain? YES NO
24. Do you have a problem with tooth pain, broken teeth or extreme sensitivity to hot/ or cold? YES NO
 If yes please describe the problem and location of the teeth affected.

25. Do you have any pressure/pain behind or around your eyes? ___ Right ___ Left YES NO
26. Do you favor one side while chewing food? ___ Right ___ Left YES NO
27. Do you have a habit of clenching your teeth during the day? YES NO
 If yes, how long have you noticed this? _____
28. Do you clench or grind your teeth at night? YES NO
 If yes, how long have you noticed this? _____
29. Do you ever awaken with a tired or sore jaw? YES NO
30. Do you have trouble falling asleep? YES NO
31. Do you have trouble staying asleep? YES NO
32. Do you snore or wake up gasping for breath? YES NO
33. Do you feel constantly and or/ easily fatigued throughout the day? YES NO
34. Do you have **unusual** vision problems? YES NO
35. Do you have numbness or tingling sensations on the face? YES NO
36. Do you have any numbness or tingling anywhere else? YES NO
 If yes, where? _____

37. Do you have facial pain? Right Left YES NO
38. Do you have pain in your jaw joint (TMJ)? Right Left YES NO
How long have you had this pain? _____
39. Do you have popping or clicking sounds in your jaw joint? Right Left YES NO
How long have you noticed these sounds? _____
40. Do you have grinding/gravel-like sounds in your jaw joint? Right Left YES NO
How long have you noticed these sounds? _____
41. Have you ever had any TMJ treatment? If yes, when _____ YES NO
-name of treating doctor: _____
42. Have you ever worn a mouth appliance prescribed by a doctor? YES NO
- name of prescribing dentist _____
-Do you still wear it? YES NO Date received _____
-Was it : Length of treatment _____
 Lower Frequency of wear _____
 Upper _____
43. Do you have any pain when doing any of the following?
 Eating Speaking Opening Wide
44. Can you open your mouth wide? YES NO
If no, when could you open wider? _____
45. Has your jaw ever been locked in an open or closed position? YES NO
If yes, how many times? _____
46. Does your bite feel "off"? If yes, since when? _____ YES NO
47. Do you have difficulty with forgetfulness or concentrating? YES NO
If yes, since when? _____
48. Does your pain interfere with your normal life style? YES NO
49. Please indicate your pain level. none 1 2 3 4 5 6 7 8 9 10 most severe
50. Please indicate your level of anxiety. none 1 2 3 4 5 6 7 8 9 10 most severe
51. Please indicate your level of depression none 1 2 3 4 5 6 7 8 9 10 most severe
52. List any serious illnesses or hospitalizations in the last two years? _____

53. List all surgeries, including dates: _____

54. Additional information _____

Signature _____ Date _____

PHYSICIAN LIST

PATIENT NAME _____ **DATE** _____

It is helpful if this form is filled out as completely as possible: thank you.

*AS PART OF HIS TREATMENT DR. KELLER WILL SEND COPIES OF HIS REPORTS TO ALL OF THE PEOPLE LISTED BELOW UNLESS YOU REQUEST THAT HE DOES NOT.
We will attempt to update this list with you every 6 months.*

Referred by: _____

Address: _____

Phone: () _____

Physical Therapist: _____

Address: _____

Phone: () _____

Dentist: _____

Address: _____

Phone: () _____

Attorney: _____

Address: _____

Phone: () _____

Physician: _____

Address: _____

Phone: () _____

Other : _____

Address: _____

Phone: () _____

Chiropractor: _____

Address: _____

Phone: () _____

I have reviewed and updated list as necessary
(review every 6 months)

X _____

date _____ date _____

date _____ date _____

date _____ date _____

NOTICE AND ACKNOWLEDGEMENT OF INFORMATION PRACTICES (PRIVACY POLICY & PROCEDURES)

As required by the **Health Information Portability and Accountability Act of 1996 (HIPAA)** Craniofacial Pain and Sleep Center is providing this notice to you. You will be asked to acknowledge receipt of a copy of this information by signing the bottom of this notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your rights under HIPAA: **You have the right to request restrictions regarding who has access to your personal or protected health information (PHI).**

- **You have the right of privacy concerning communications regarding your PHI.** Craniofacial Pain and Sleep Center will take reasonable steps to prevent unauthorized disclosure and unauthorized re-disclosure of your PHI without proper authorization.
- **You have the right to inspect and have a copy of your PHI.** *All records contained in the patient's file are the property of Craniofacial Pain and Sleep Center.* If patient requests copies of his/her records, Craniofacial Pain and Sleep Center reserves the right to charge a reasonable fee. All requests must be in writing.
- **You have the right to amend your PHI.** You have the right to amend your PHI if you believe that it is incorrect or incomplete. Craniofacial Pain and Sleep Center will review your request and either grant your request or explain the reason why it will not be granted. In the event your request is granted, Craniofacial Pain and Sleep Center will not destroy an entry, but rather designate it as an error, leaving the original entry legible. In the event your request is not granted, you may submit a statement of disagreement that will accompany the information in question in all future disclosures.
- **You have the right to receive a record of all non-routine disclosures of your PHI.** Disclosures of PHI prior to 4/03 will not be accounted. Records associated with treatment, payment and healthcare operations will not be recorded.
- **You have the right to receive a printed copy of the Notice of Privacy Practices.**
- **You have the right to complain about Craniofacial Pain and Sleep Center's privacy policies, procedures or actions.** Craniofacial Pain and Sleep Center will not retaliate or discriminate against you for submitting a complaint or reporting a suspected violation. Please notify the office staff if you suspect a violation so that we may take the necessary action.

Authorization of use or disclosure of protected health information: Craniofacial Pain and Sleep Center will use and disclose your personal health information for the purposes of treatment, payment and healthcare operations, including, but not limited to, contacting the doctors/attorney you have listed in your file regarding your exam findings and our services. Legally mandated disclosures that may be made without your authorization are for the purposes of: treatment; payment; healthcare operations; law enforcement; public health; reporting of abuse, neglect or domestic violence; subpoena, court order or summons; organ donation; coroner or posthumous medical examination; to avert threats to public/ personal health or safety; disaster relief.

Any other use or disclosure of protected health information requires written authorization by the patient and the patient may revoke this authorization in writing at any time.

Craniofacial Pain and Sleep Center Duties: It is the policy of Craniofacial Pain and Sleep Center that all personnel must preserve the integrity and confidentiality of medical and other sensitive information pertaining to our patients. The purpose of this policy is to ensure that Craniofacial Pain and Sleep Center and its officers, employees and agents have the necessary medical and other information to provide the highest quality of care possible while protecting the confidentiality of that information to the highest degree possible so that patients do not fear to provide information to Craniofacial Pain and Sleep Center and its officers, employees and agents for the purposes of treatment. This policy will be review annually.

Craniofacial Pain and Sleep Center recognizes that medical information collected about patients must be accurate, timely, complete and available when needed. Craniofacial Pain and Sleep Center will complete and authenticate medical records in accordance with the law, medial ethics and accreditation standards. Craniofacial Pain and Sleep Center will maintain medical records for the retention periods required by law and professional standards.

All officers, agents and employees of Craniofacial Pain and Sleep Center must adhere to this policy. Craniofacial Pain and Sleep Center will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action.

Right to revise privacy practices: Craniofacial Pain and Sleep Center reserves the right to modify its privacy practices and that should it do so, the revised notice will be made available to patients upon their request.

Privacy Officer for Craniofacial Pain and Sleep Center: Brenda Neiry, Manager-2627 Redwing Rd. #300 Fort Collins, CO 80526; telephone 970.484.0250.

Effective Date: This privacy policy/procedure is effective on July 15, 2010.

Revisions: 7.15.10

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

I _____ acknowledge receipt of Notice of Practices Privacy Policy & Procedures

Signature

Date

FINANCIAL POLICY

Patient Name _____

CONFIRMATION OF ELIGIBILITY

We highly recommend that you call the number on the back of your insurance card, prior to your first appointment, to find out whether services are a covered benefit under your medical and/or dental plan. This will outline what you, the insured, can expect in payment from your insurance company.

PAYMENT

Regardless of insurance coverage, payment is due at time of service. As a courtesy, we will file commercial insurance for you. If services are a covered benefit, payments should be made directly from your insurance company to you. It has been explained to me that I am responsible for the entire professional fee, and my insurance company is responsible to me.

However, if services rendered remain outstanding, the patient agrees that the assignment of benefits will be made to the provider. Please note that any of the insurance check(s) received will be applied to any outstanding balance in the patient's account.

I understand that there will be additional charges for broken or lost appliances and missed appointments. If you are unable to keep your scheduled appointment, we ask that you kindly contact our office 24hours in advance.

As a payment option, we accept Visa, MasterCard, and Discover.

IMPORTANT

Dr. Keller is NOT a Medicare or Medicaid or Tricare provider and, as such, is an "Opt-Out Provider". As a patient of Dr. Keller, you enter in to a private contract with our office whether or not you are a Medicare, Medicaid and/or any other insurance beneficiary. Insurance coverage is a contract between yourself, your employer, if employed, and your insurance company. All treatment provided in our office will be on the same basis as a non-insured patient, including the fee. Therefore, it is imperative that our office overhead not be increased because of unnecessary demands made by the insurance carrier or union. Our office is not a network provider for any insurance company. As long as you are able to choose your provider and there are benefits available, there should be some type of payment rendered to you directly.

SIGNED

DATE

INFORMED CONSENT FOR OUR PATIENTS WHO EXHIBIT
SYMPTOMS OF TMJ DISORDER

Disorders of the temporomandibular joint can mimic other dental and medical problems. The diagnosis is very important, because some medical problems have similar headache or neck ache symptoms that can be life threatening; for example, intracranial tumor or coronary heart disease. The patient can help by giving the clinician a detailed medical and family history, including a history of any food or drug allergies. Treatment for TMJ disorder can be lengthy and frustrating. The patient must inform the clinician about changes in jaw function. The best therapeutic improvement is from good patient-clinician communication. Please call our office anytime if there is a problem or question about treatment.

LENGTH OF TREATMENT: Treatment time can vary widely. In general, the treatment plan will be more lengthy and complicated if the symptoms are severe, or if the problem has existed for a long time. Mild clicking, with occasional muscle spasm and headache may be treated within six months. Long-standing arthritic joint disorder may require surgery, prosthetic, orthodontic, and/or restorative treatment procedures.

We will make our best effort to diagnose and treat your TMJ disorder with timely and cost-effective methods. The most proven and conservative techniques will be used. However, you should be aware that there is much debate in the scientific literature on the most effective techniques or combination of treatment modalities. These include, but are not limited to, prosthetic splints, restorative dental procedures, TMJ surgery, biofeedback, phonophoresis, transcutaneous electrical nerve stimulation (TENS), acupuncture, muscle trigger point injections, psychological counseling, orthodontic and orthopedic appliances. Orthodontic, orthopedic, and prosthetic appliances may be swallowed or inhaled. Swallowed appliances may have to be surgically removed. Inhaled appliances can lead to respiratory arrest and death.

Some TMJ symptoms may get worse with treatment. Patients with long-standing arthritic joint disease or traumatic injury can demonstrate more severe symptoms during treatment.

Oral hygiene is very important during treatment. Decalcification of the teeth and gum disease can occur even with good brushing. A topical fluoride is provided to prevent the majority of problems.

UNUSUAL OCCURRENCES: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasms, ear and back problems, and limb numbness are all possible occurrences.

TMJ injections and manipulation of your jaw may be required. TMJ injections can result in damage to the facial nerve, which innervates the side of the face and eyelid. Also, damage to the trigeminal nerve can occur, either of which can result in numbness or paralysis of the affected nerve branch and muscles.

Most of these unusual occurrences and complications are very infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

I hereby authorize Richard H. Keller, D.D.S., M.P.S. and whomever he designates as his assistant and/or technician to perform such procedures necessary to diagnose and treat my temporomandibular joint (jaw joint) as a possible cause of symptoms indicated on the initial exam questionnaire. I am fully aware that the symptoms may be medical in nature and may require medical consultation and treatment.

The doctor has explained to me the diagnosis and therapy indicated for my condition.

I understand that because of the complexity of the problems, no warranties, guarantees of results, or satisfaction can be given. I accept treatment under these conditions.

I further understand that if orthotic therapy is indicated, and my symptoms are alleviated to the extent that I have substantially improved for three months, a second phase of treatment is often necessary to complete my case.

Dr. Keller will perform the following second phase procedures:

1. Myofunctional therapy
2. Equilibration

Dr. Keller will refer to the appropriate medical or dental physician the following second phase procedures:

1. Crown and/or bridge restorations
2. Orthodontia
3. Combination of crown and/or bridge restorations and orthodontia
4. A semi-permanent orthotic or partial denture
5. Complete dentures
6. Implant Prosthodontics

I consent to the taking of photographs and x-rays before, during and after treatment.

I certify that I have read, or had read to me, the contents of this form. I realize the risks and limitations involved, and I consent to treatment.

Date

Patient/Parent