MEDICAL QUESTIONNAIRE

Name: (first)____________________ (last)___________________ (MI)_____Date____________

Address:________________________________ City:__________________State____zip______

Phone(Hm)_________________(wk)________________(cell)_________________Text ok? Y N

Email___________________Occupation___________________Employer__________________

Date of Birth__________ Age_____ • Male • Female

I give permission to speak to the following people regarding my account:
Name _________________ Relationship ______ Name _________________ Relationship _____

(Office Use): Height________ Weight_______ O2_______ Pulse_______

CHIEF COMPLAINTS: What is the chief complaint that you are seeking treatment in this office? Please identify your chief complaint as #1, list all other symptoms in priority #2-9 (for example)

- ___ Headache Pain
- ___ Ear Pain
- ___ Jaw Pain
- ___ Pain when chewing
- ___ Facial Pain
- ___ Neck Pain
- ___ Limited ability to open
- ___ Jaw joint locking
- ___ Jaw joint noises
- ___ Ear congestion
- ___ Dizziness
- ___ Tinnitus
- ___ Morning hoarseness
- ___ Other__________________
- ___ Dry mouth upon waking
- ___ Fatigue
- ___ Difficulty falling asleep
- ___ Tossing and turning frequently
- ___ Repeated awakening
- ___ Feeling unrefreshed in the a.m.
- ___ Significant daytime drowsiness
- ___ Frequent heavy snoring
- ___ Snoring effects sleep of others
- ___ Gasping when waking
- ___ Told that “I stop breathing” during sleep
- ___ Unable to tolerate CPAP
- ___ Teeth grinding or clenching

Do any of the above chief complaints affect your daily life and how?

What are the results you are hoping to get from treatment?

____

____patient initials

Accidents/Surgeries/Illnesses

MEDICAL QUESTIONNAIRE

_______________________________________ _______________________________________

_______________________________________ _______________________________________
Or • See provided list

Allergies

_______________________________________ _______________________________________

_______________________________________ _______________________________________
Or • See provided list

Current Medications/Supplements

_______________________________________ _______________________________________

_______________________________________ _______________________________________
Or • See provided list

I am currently seeking care from the following providers:

Primary Care Physician: _______________________________________

Dentist: _______________________________________

Chiropractor: _______________________________________

ENT: _______________________________________

Dermatologist: _______________________________________

Cardiologist: _______________________________________

Oncologist: _______________________________________

Other: _______________________________________

Other: _______________________________________
I give permission to inform my providers of my treatment: • Yes • No
_____patient initials

MEDICAL QUESTIONNAIRE

Have you previously been diagnosed with Obstructive Sleep Apnea?	• Yes	• No
Does your family have a history of OSA?	• Yes	• No
Do you work swing shift or nights?	• Yes	• No
Do you exhibit any of the following symptoms?		
Chronic snoring	• Yes	• No
Witnessed apneas or breathing pauses during sleep	• Yes	• No
Daytime sleepiness	• Yes	• No
Drowsiness while driving	• Yes	• No

Do you have any of the following conditions?

High Blood Pressure	• Yes	• No	Acid Reflux Disease	• Yes	• No
Diabetes	• Yes	• No	Depression	• Yes	• No
Low thyroid	• Yes	• No	Headaches	• Yes	• No
Heart Disease	• Yes	• No	Bruxism (Clenching)	• Yes	• No
Stroke	• Yes	• No	HIV/Aids	• Yes	• No
Pregnancy	• Yes	• No	Hepatitis	• Yes	• No

For what reasons are you seeking treatment at this office?

____

EPWORTH SLEEPINESS QUESTIONNAIRE: 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 have affected you. Use the following scale to check the most appropriate number for each situation. 0=never doze,1=slight chance of dozing,2=moderate chance of dozing,3=high chance of dozing

	0	1	2	3
Sitting and reading	•	•	•	•
Watching TV	•	•	•	•
Sitting, inactive, in a public place (theater,meeting, etc)	•	•	•	•
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 traffic	•	•	•	•

Score____________

____patient initials

MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS: Do you have any of the following problems or conditions?

Constitutional

- Chills
- Chronic Pain
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight gain
- Weight Loss

Ear, Nose, Throat (ENT)

- Bleeding gums
- Dry mouth
- Earache
- Hearing loss/impairment
- Hoarseness
- Nasal Congestion
- Nose bleeds
- Oral ulcers
- Ringing in the ears
- Sinus problems
- Sore throat
- Swallowing difficulty

Musculoskeletal:

- Extremity weakness lower
- Extremity weakness upper
- Joint pain
- Joint redness
- Joint swelling
- Muscle atrophy
- Muscle cramps
- Muscle pain
- Numbness or tingling

FAMILY HISTORY: Has any parent or sibling experienced any of the following conditions?

Heart disease • Yes • No
High blood pressure • Yes • No
Diabetes • Yes • No
Depression • Yes • No
Stroke • Yes • No
Sleep Apnea • Yes • No
Cancer • Yes • No

SOCIAL HISTORY:

Recent alcohol consumption:

- Never
- 1-3 drinks per week
- 1-2 drinks per day
- > 2 drinks per day

History of alcoholism: • Yes • No

Recent tobacco usage:

- Never
- Less than 1 pack per week
- Less than 1 pack per day
- 1 pack or more per day

History of smoking/tobacco use: • Yes • No
Years of use:______years
Marijuana usage: • Yes • No
Frequency______________________

____patient initials

Caffeine intake:

Most common form of caffeine intake • Coffee •Tea. • Energy drinks • Soda • Caffeine Capsule
_______ Servings of caffeine in the morning
_______ Servings of caffeine in the afternoon
_______ Servings of caffeine in the evening

Anything else you would like to mention regarding your family or social history?:

____

____

____

____

____ _________________________
Patient Signature Date

3D CONE BEAM INFORMED CONSENT

MEDICAL QUESTIONNAIRE

I understand I am going to be having a 3D Cone Beam scan done. This scan is a three dimensional evaluation of my skull. Several slices will be acquired from the scan in accordance with my doctor's needs and expectations.

I understand that Dr. Jim Beck is not a radiologist and will not be looking at my scan for purposes other than the diagnosis of temporomandibular disorder and/or obstructive sleep apnea.

Dr. Jim Beck has given me the option to have my scan read by a radiologist and a report obtained from this radiologist regarding the entire scope of the scan.

_____ I have agreed to send my scan to a radiologist and understand the fee of $90 will be paid directly by me to TMJ-Sleep Colorado to obtain this reading.

Patient_______________________________________ Date___________________

OR

_____ I am refusing to have my scan sent to a radiologist. I have had the opportunity to discuss my refusal of treatment. My questions have been answered. By signing, I am making it aware that I am voluntarily refusing to proceed with the Skull & Facial Survey. Consequently, I do not hold Dr. Jim Beck, TMJ-Sleep Colorado, any associate, or any staff member responsible for any diagnosis, injury, or harm that I may suffer as a result of my refusal to follow this recommendation.

Patient_______________________________________ Date____________________

Witness______________________________________ Date____________________

MEMBER AUTHORIZATION FOR A DESIGNTED REPRESENTATIVE TO APPEAL A DETERMINATION

Date: ______________________________________

Member Name: ______________________________________

Insurance Company: ______________________________________

Member ID: ______________________________________

I hereby authorize Triton Medical Solutions to represent me as my Designated Representative in all aspects of processing my appeal.

I understand that the information may be privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

X____ _________________
Signature of Member or Legal Guardian Date

Representative: ____

Title: Billing Coordinator

X____ _________________
Signature of Designated Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

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

____________________________________ Signature. __________________Date

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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)_______________________________________

____________________________________ Signature of Staff Member

________________ Date