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

_____ _____

_____ _____

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

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

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

Constitutional

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

Ear, Nose, Throat (ENT)

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

Musculoskeletal:

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

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

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

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 $105 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 sending the Skull & Facial Survey to be read by a radiologist. 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..

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

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

Patient Name:_____ Date of Birth:_____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to TMJ Sleep Colorado or the providers individually for services rendered to my dependents or myself by the provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits; and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balances due that TMJ Sleep Colorado is unable to collect from my insurance carrier. I agree to forward all health insurances or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare:
I certify that any information I provide, if any, in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to TMJ Sleep Colorado by the Medicare program.

Financial Agreement:
I acknowledge, that as courtesy, TMJ Sleep Colorado will bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full; including but not limited to any co-payments, co-insurances and/or deductible, or charges not covered by insurances. I acknowledge that failure to pay for services not covered by insurances may result in termination from TMJ Sleep Colorado. I understand that a $45 fee will apply for returned checks. I understand and agree there is a $50 fee for no showing an appointment or for cancelling an appointment that was not canceled within 24 hours of the scheduled time. I acknowledge that TMJ Sleep Colorado may utilize the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing.

HIPAA PRIVACY & RELEASE OF INFORMATION AUTHORIZATION
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members listed below.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

If TMJ Sleep Colorado needs to contact me and I am unavailable, I authorize them to leave me a detailed message that may be included but not limited to test results, medications, referrals.

Patient/Guardian Signature:_____ Date:_____