CRANIOFACIAL PAIN & SLEEP CENTER
Kingdon K. Brady, DDS

Fort Collins Office
2627 Redwing Rd Suite 300
Fort Collins, CO 80526

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

Medicare does not cover services related to Temporomandibular Joint Disorder (TMJ). This office cannot guarantee that the insurance company will reimburse patients 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 if there is no outstanding balance. 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 coverage 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, Credit Cards and Care Credit 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 _____

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. The Craniofacial Pain & Sleep Center 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. Kingdon K. Brady, or staff.

I herby 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

___ Allergies
___ Anemia
___ Arthritis
___ Asthma
___ Breathing problems
___ Chest Pain
___ Chronic Cough
___ Creutzfeldt-Jakob Disease
___ Diabetes
___ Ear problems
___ Epilepsy
___ Excessive thirst
___ Excessive urination
___ Fainting Spells
___ Glaucoma
___ Heart murmur
___ Heart attack
___ Hepatitis A, B or C
___ High blood pressure
___ HIV
___ Kidney disease
___ Liver disease
___ Low blood pressure
___ Malignancies
___ Neurological Problems
___ Rheumatic fever
___ Sinus problems
___ Sleep Apnea
___ Stroke
___ Thyroid disorder
___ Tonsillitis
___ Tuberculosis
___ Ulcers - gastric
___ _____
___ _____
___ _____

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

   _____
   _____
   _____
   _____
   _____
10. Have you ever received a blow to the face/head in any other type of accident or assault? YES NO
    If yes, please describe.

    Date Description

    _____
    _____
    _____

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
    Are you taking aspirin? YES NO

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? 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 had orthodontic treatment (braces)? YES NO
    Name of prescribing dentist _____
    Date treatment started _____
    Length of treatment _____
43. 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: ____ Lower ____ Upper Length of treatment _____
    Frequency of wear _____
44. Do you have any pain when doing any of the following?
    _____ Eating _____ Speaking _____ Opening Wide
45. Can you open your mouth wide? YES NO
    If no, when could you open wider? _____
46. Has your jaw ever been locked in an open or closed position? YES NO
    If yes, how many times? _____
47. Does your bite feel "off"? If yes, since when _____ YES NO
48. Do you have difficulty with forgetfulness or concentrating? YES NO
    If yes, since when? _____
49. Does your pain interfere with your normal life style? YES NO
50. Please indicate your pain level. none 1 2 3 4 5 6 7 8 9 10 most severe
51. Please indicate your level of anxiety. none 1 2 3 4 5 6 7 8 9 10 most severe
52. Please indicate your level of depression none 1 2 3 4 5 6 7 8 9 10 most severe
53. List any serious illnesses or hospitalizations in the last two years? _____
    _____
54. List all surgeries, including dates: _____
    _____
55. Additional Information _____
    _____
    _____

Signature Date

Patient Name _____ Date _____

EPWORTH Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze-off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze-off
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching television	_____
3. Sitting inactive in a public place (i.e. theater)	_____
4. As a car passenger for an hour without a break	_____
5. Lying down to rest in the afternoon	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. Driving a car, stopped for a few minutes in traffic or at a red light	_____
Total Score	_____

Score Results:
1-6 Normal
7-8 Average
9 + Seek medical advise

Behavior During Sleep

Use the following scale to choose the most appropriate number for each situation.

0 = Never during a usual night
1 = Less than once a week
2 = Once to about half the nights per week
3 = Half the nights to almost every night
4 = Almost always or every night
7 = Don't know or haven't been told

During your usual sleep, you have noticed or have been told you do the following:

Situation	0-4 or 7
1. Snore loudly	_____
2. Stop breathing	_____
3. Choke, struggle for breath	_____
4. Toss and turn frequently	_____
5. Wake up with headache	_____

Usual number of hour you sleep per night _____
Number of times you rise to use the toilet _____

STOP-BANG Sleep Questionnaire:

Height: _____ inches Age: _____ Gender: M / F Neck Circumference: _____ inches Airway: _____ mm^2

	Patient Questionnaire	Yes	No
Snoring	Do you snore loudly? (Louder than talking or loud enough to be heard through closed doors)		
	Do you toss and turn frequently?		
Tired	Do you often feel tired, fatigued, or sleepy during the daytime		
	Do you wake up with headaches?		
Observed	Has anyone observed you stop breathing during your sleep?		
	Do you choke, struggle, or feel out of breath?		
Blood **P**ressure	Do you have or are you being treated for high blood pressure?		

	Clinician Observations (For office use)		
BMI	Is BMI more than 35 kg/m^2?		
Age	Is age over 50 years old?		
Neck Circumference	Is the neck circumference greater than 16 (female) or 17 (male)?		
Gender	Is the gender male?		

PHYSICIAN LIST

PATIENT NAME _____ **DATE** _____

It is helpful if this form is filled out as completely as possible. *Dr. Brady will send copies of his initial report to each person listed below.*

Referred by: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Physical Therapist: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Dentist: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Attorney: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Physician: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Other: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Chiropractor: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

Other: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Fax: _____

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 confidentially 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 reviewed 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, medical 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: Kingdon K Brady - **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: 1.21.2016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

I _____ acknowledge receipt of Notice of Information 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

- **Applicable payment is due at time of service.** As a courtesy, we will file commercial insurance for you. If we are contracted with your insurance carrier and the services are a covered benefit, payments will be made directly to the Provider. If we are not contracted with your insurance carrier or the services are not a covered benefit, it has been explained to me that I am responsible for the entire professional fee, and my insurance company is responsible to me. I am responsible for all fees associated with collection on the account should the account become delinquent, including but not limited to attorney & collection agency fees.

- 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 24 hours in advance.

- **I understand that the initial exam fee does not include the cost of the CT scan.** If I choose not to go forward with treatment, and want the CT scan, there is a $400.00 records fee to certify and release the scan.

IMPORTANT

- **Dr. Brady is NOT a Medicare or Medicaid provider and, as such, is an "Opt-Out Provider". As a patient of Dr. Brady's, you enter in to a private contract with our office whether or not you are a Medicare, Medicaid and/or any other insurance beneficiary.**
- We are unable to guarantee payment by your insurance carrier, even if the services rendered are a covered benefit.

_____

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. Dr. Brady recommends regular visits with a dental hygienist to keep oral hygiene as good as possible.

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 Kingdon K. Brady, D.D.S and whomever is designated 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.

I understand that because of the complexity of the problems, no warranties, guarantees of results, or satisfaction can be given. I understand that if at any time I decide to terminate treatment, I have two options:

1. I will return any appliances/orthotics used for treatment to this office, or

2. I will provide a signed letter from the doctor that has agreed to supervise utilization of appliances/orthotics.

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. Brady will perform the following second phase procedures:

1. Myofunctional therapy
2. Equilibration

Dr. Brady 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.

Oral orthotics will need to be evaluated as deemed necessary by Dr. Brady as long as the patient has an oral orthotic.

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 under these conditions.

_____ _____

Patient/Parent Date