CRANIOFACIAL PAIN & SLEEP CENTER
Kingdon K. Brady, DDS

Fort Collins Office
2627 Redwing Rd Suite 300
Fort Collins, CO 80526
Ph: 970-484-0250
Fax: 970-484-1522

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 _____

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, the office will return the voided check to the insurance company. The patient is responsible for verifying benefits, obtaining referrals or obtaining prior authorizations/certifications. Please note, the Craniofacial Pain & Sleep Center will as a courtesy file claims if appropriate. 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
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? _____ Was it locked __open or __closed?
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. Have you had a sleep study? If yes please bring a copy YES NO
51. Do you stop breathing when you are asleep? YES NO
52. Do you wake up gasping for breath? YES NO
53. Do you feel tired in the morning? YES NO
54. Do you awaken with a headache? YES NO
55. Do you have stiffness or pain in your jaw joint area? (TMJ) YES NO
56. Do your jaw muscles feel tired in the morning? YES NO
57. Average number of hours per night you sleep _____
58. Do you have "restless legs" when you lay down to sleep? YES NO
59. Have you tried a C-PAP YES NO
    With what success? _____

60. If you snore, have you tried surgical corrections? YES NO

What type?_____

Results _____

61. What other approaches to reducing your snoring / sleep apnea have you attempted?

_____

_____

62. Please indicate your pain level. none 1 2 3 4 5 6 7 8 9 10 most severe

63. Please indicate your level of anxiety. none 1 2 3 4 5 6 7 8 9 10 most severe

64. Please indicate your level of depression none 1 2 3 4 5 6 7 8 9 10 most severe

65. List any serious illnesses or hospitalizations in the last two years? _____

_____

_____

66. List all surgeries, including dates: _____

_____

_____

67. Additional Information _____

_____

_____

_____

Signature _____ Date _____

Please note, it is important for you to complete page 6 prior to your appointment.

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

Medical Information Release Form
(HIPAA Release Form)

Last Name: _____ First Name: _____Birthdate _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Other _____
[ ] Other _____
[ ] Information is not to be released to anyone.

The Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my [ ] home [ ] work [ ] cell Number _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time of day to reach me is between _____ to _____

Signed: _____ Date: ____/____/_____

FINANCIAL POLICY

Patient Name _____

CONFIRMATION OF ELIGIBILITY

- **It is your responsibility to 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. It has been explained to me, & I understand, that I am responsible for the entire professional fee, and my insurance company is responsible to me. I authorize Craniofacial Pain & Sleep Center, PLLC (CFPSC) to release to my insurance company or its agents, information for any insurance claim. I also permit a copy of this authorization be used in place of the original. In the event of nonpayment or underpayment of any charges/services by my insurance company, I agree to be responsible for those charges, including a fee of 1.5% per month on my unpaid balance. I agree to utilization of a collection agency, being responsible for all collection fees including but not limited to collection agency fees or submit a binding arbitration with CFPSC (the arbitrator to be selected by CFPSC), to be held in Fort Collins, Colorado, regarding my dispute or collection concerning any amount in lieu of court proceedings. The Colorado Uniform Arbitration Act shall apply to all such disputes, with the exception that CFPSC shall select the arbitrator. I agree to pay for all arbitration (or collection) costs as well as all fees charged for time spent by any and all CFPSC representatives and witnesses, to be billed at a minimum of $300.00 per hour pursuing any such dispute or collection matter. The arbitrator's decision shall be additional binding judgment to be entered in a Larimer County Colorado Court.

- 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 contact our office 48 hours in advance. It is at the discretion of the office to charge for broken appointments.

- **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 $500.00 records fee to 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.

By my signature below, I acknowledge reading and agreeing to the above terms.

_____

SIGNED

_____

DATE

INFORMED CONSENT FOR AN ORAL AIRWAY DILATOR APPLIANCE

I, (NAME) _____ have selected treatment for an oral airway dilator appliance while sleeping in an attempt to alleviate snoring and obstructive sleep apnea. The purpose of this appliance is to maintain an open airway passage which permits normal quiet breathing during sleep. I have been told that while this device has had an excellent record in the majority of patients, due to physiological, anatomical variations, and individual tolerance of the appliance, there can be no guarantee that it will be totally successful.

By increasing the vertical intraoral dimension, as well as horizontal advancement of the mandible, your oral appliance dilates the pharyngeal opening and prevents collapse of the tongue on the airway. It repositions the condyles and captures the disc in a physiologic position conducive to ligament healing. The goal of treatment is to prevent reciprocal clicking while it is being worn, and alleviate temporomandibular joint related symptoms. It enlarges tongue space but does not adversely affect swallowing. It allows the masticatory muscles to remain passive, comfortable and not hyperactive.

Certain precautions are recommended to prevent the occurrence of a bite shift. You will be given written and verbal instructions to prevent any bite shift. Your instructions are to remove the lower component 10 to 15 minutes before the upper is removed. During this period we recommend chewing on the upper component in a centric bite position. After removal of the upper you are instructed to try and bite on the posterior teeth. If you are still unable to bite in the centric occlusion position by 10:00AM then we recommend chewing on a piece of sugarless gum. As soon as you feel posterior interocclusal contact, dispose of the chewing gum. This regiment works about 98% of the time.

For many patients bite shift is never a problem. Usually it is the patient who does not follow the recommended AM procedures, and therefore develops the posterior open bite. They only bite on the anterior teeth and they cannot get the mandible back to their usual centric occlusal position. This condition is usually asymptomatic. If there is a complaint, it is that they cannot masticate their food as well as before.

It is probable that these patients most likely had an underlying temporomandibular disorder (TMD). Patients with pre-existing conditions, such as a reducing disc displacement and muscle splinting/muscle spasm, may become unable to close into central occlusal after use of an oral airway dilator. Physiologists refer to this condition as a “physiologic set point”. The original centric occlusion was an adaptive position that was not as compatible to healthy physiological function as the new position. Therefore, the brain, nerves and reprogrammed muscles refuse to go back to the old position.

An oral airway dilator and muscle deprogrammer, in these rare cases, creates a physiological set point that facilitates better breathing and a more open airway; and the brain, nerves and muscles refuse to close in the old maladaptive centric occlusion. This is not necessarily bad. These patients are probably breathing better and often experience a decrease or disappearance of "TMD" symptoms. Good restorative dental work is often the recommended solution for this rare bite shift.

In addition to the above, I understand and am aware of the following conditions which may occur. Although the oral airway dilator appliance is not intended to change my jaw or teeth, it may happen. If I notice these occurrences, I will contact the office immediately. If I have any dental, jaw or muscle discomfort, other than mild discomfort for the first hour or so in the morning, I will inform the office. Since this appliance is designed to be highly retentive during sleep, existing dental restorations, including crowns and/or bridges may occasionally loosen or fail. If this occurs, I agree to have the necessary dental work attended to as soon as possible.

Oral appliances can wear and break. The rare possibility that broken parts from them may be swallowed or aspirated does exist. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to a heart attack, stroke, and even death. Should you ever decide not to utilize treatment with your intraoral sleep appliance, consult with your primary care physician or call this office for recommendations of alternative therapy such as CPAP and/or surgery.

The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore, the device must be worn for a lifetime to be effective. Over time, simple snoring may develop into sleep apnea and may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least twice a year to ensure proper fitting and the mouth examined at that time to assure a healthy condition. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.

I have received, read, or had read to me, the contents of this form. Further testing and procedures may be necessary and no warrantees or guarantee of success was given or implied. Furthermore, I give my permission for my diagnostic and treatment records and photographs to be used for purposes of research, education or publication in professional journals. I also accept financial responsibility for this treatment. With all of the foregoing in mind, I authorize treatment and I have received a copy of this disclosure.

Signature: _____ Date: _____