Sherwin Arman, DMD
Diplomate, American Board of Orofacial Pain

Center for Facial Pain
& Dental Sleep Medicine

PATIENT INFORMATION

(PLEASE USE BLACK PEN ONLY)

Date: _____ Preferred Name: _____

Patient Name: _____ DOB: _____ / _____ / _____
First Middle Last Month Day Year

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Age: _____ Gender (F/M): _____
(FOR APPOINTMENT REMINDERS)

Preferred method of communication: ☐ Cell ☐ Home ☐ Work ☐Email

Patient's SS#: _____-_____-_____ Marital Status (S/M)_____ Occupation: _____

Person Responsible for Payment: _____ _____
First Middle Last Relationship

Emergency Contact: _____ _____ _____
Name Phone Relationship

Preferred Pharmacy: _____ Phone: _____

Pharm Address: _____

Purpose of Visit: _____

Briefly list your chief complaints: _____

_____

How did you hear about us? (DOCTOR) (INSURANCE (GOOGLE) (UCLA/UCI) (PATIENT/FRIEND) (RELATIVE/FAMILY)

_____

Address: _____ Phone: _____

WE WOULD LIKE TO KEEP YOUR HEALTHCARE PROVIDERS UP TO DATE REGARDING YOUR TREATMENT, PLEASE INCLUDE THEIR INFORMATION BELOW.

NOTE: By putting their info below, you are giving us a consent to disclose your protected health information, medical condition or test results with them if needed.

Physicians Info and Dentists Info

- Doctor's Name: _____
  Specialty: _____
  Address: _____
  Office No.: _____-_____-_____
  Fax No.: _____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address: _____
  Office No.: _____-_____-_____
  Fax No.: _____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address: _____
  Office No.: _____-_____-_____
  Fax No.: _____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address: _____
  Office No.: _____-_____-_____
  Fax No.: _____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address: _____
  Office No.: _____-_____-_____
  Fax No.: _____-_____-_____

MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1) hospitalization for illness or injury _____	☐	☐
2) an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3) heart problems or cardiac stent within the last six months	☐	☐
4) history of infective endocarditis _____	☐	☐
5) artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6) pacemaker or implantable defibrillator _____	☐	☐
7) artificial prosthesis (heart valve or joint)_____	☐	☐
8) rheumatic or scarlet fever_____	☐	☐
9) high or low blood pressure_____	☐	☐
10) a stroke (taking blood thinners)_____	☐	☐
11) anemia or other blood disorder_____	☐	☐
12) prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
13) emphysema, sarcoidosis_____	☐	☐
14) tuberculosis_____	☐	☐
15) asthma_____	☐	☐
16) breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17) kidney disease_____	☐	☐
18) liver disease_____	☐	☐
19) jaundice_____	☐	☐
20) thyroid, parathyroid disease, or calcium deficiency_____	☐	☐
21) hormone deficiency_____	☐	☐
22) high cholesterol or taking statin drugs_____	☐	☐
23) diabetes (HbA1c=_____)_____	☐	☐
24) stomach or duodenal ulcer_____	☐	☐
25) digestive disorders (i.e. gastric reflux)_____	☐	☐
26) osteoporosis or osteopenia (i.e. taking biphosphonates)	☐	☐
27) arthritis_____	☐	☐
28) glaucoma_____	☐	☐
29) contact lenses_____	☐	☐
30) head or neck injuries_____	☐	☐
31) epilepsy, convulsions (seizures)_____	☐	☐
32) neurologic problems (attention deficit disorder)_____	☐	☐
33) viral infections and cold sores_____	☐	☐
34) any lumps or swelling in the mouth_____	☐	☐
35) hives, skin rash, hay fever_____	☐	☐
36) STI / STD_____	☐	☐
37) hepatitis (type____)_____	☐	☐
38) HIV / AIDS_____	☐	☐
39) tumor, abnormal growth_____	☐	☐
40) radiation therapy_____	☐	☐
41) chemotherapy_____	☐	☐
42) emotional problems_____	☐	☐
43) psychiatric treatment_____	☐	☐
44) antidepressant medication_____	☐	☐
45) alcohol _____	☐	☐
46) street drug use _____	☐	☐
ARE YOU:		
47) presently being treated for any other illness _____	☐	☐
48) aware of a change in your health (i.e. fever, new cough)	☐	☐
49) taking medication for weight management _____	☐	☐
50) taking dietary supplements _____	☐	☐
51) often exhausted or fatigue _____	☐	☐
52) experiencing frequent headaches _____	☐	☐
53) a smoker, smoked previously or use smokeless tobacco	☐	☐
54) often unhappy or depressed _____	☐	☐
55) FEMALE – taking birth control pills _____	☐	☐
56) FEMALE – pregnant _____	☐	☐
57) MALE – prostate disorders _____	☐	☐

Describe any current medical condition, impending surgery, or other reasons that may possibly affect medical or dental treatment.

List all medications, supplements, or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature _____ **Date** _____

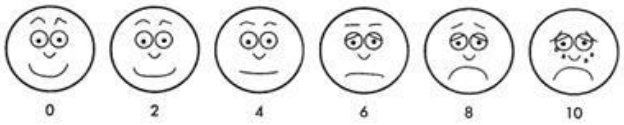
PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU ARE TAKING.

PAIN RATING SCALE

Name: _____ **Date:** _____

Please rate your pain from **1 (lowest/no pain)** to **10 (highest/in a lot pain)**

1. Rate how much PAIN you are experiencing RIGHT NOW at this moment. ☐
2. Rate INTENSITY OF YOUR PAIN at its HIGHEST intensity over the last 5 days. ☐
3. Rate INTENSITY OF YOUR PAIN at its LOWEST intensity over the last 5 days. ☐
4. Rate YOUR MOOD at its AVERAGE over the last 5 days: Please circle



5. Rate how much your PAIN/PROBLEM INTERFERES with your JAW FUNCTION (chewing, eating, yawning, talking etc.) ☐

Circle all words that describe your pain this month:

Aching	**Throbbing**	**Shooting**	**Stabbing**	**Fearful**	**Sharp**	**Heavy**
Burning	**Exhausting**	**Splitting**	**Sickening**	**Cramping**	**Tender**	**Dull**

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Use the following scale to choose the most appropriate number for each situation:
0 (lowest chance of dozing) to 3 (highest chance of dozing)

Situation	**Chance of dozing**
Sitting and reading ……	0 1 2 3
Watching TV ……	0 1 2 3
Sitting, inactive in a public place (e.g. a theatre or a meeting)…..	0 1 2 3
As a passenger in a car for an hour without a break ……..	0 1 2 3
Lying down to rest in the afternoon when circumstances permit …	0 1 2 3
Sitting and talking to someone ……..	0 1 2 3
Sitting quietly after a lunch without alcohol ……	0 1 2 3
In a car, while stopped for a few minutes in the traffic ……..	0 1 2 3
Total ……	☐

GENERAL GUIDELINES OF INSURANCE COVERAGE

It is our goal to give the most accurate information about insurance coverage for our services. As a courtesy, we will attempt to contact the patient's insurer to **verify benefits (coverage)** and obtain **pre-authorization**, when possible.

General guidelines regarding insurance are as follows:

- In most instances, the **insurance deductible must first be fully met** via out of pocket payment from patient before any percentage of treatment will be covered by insurance.

- When an insurer has verified benefits for a particular treatment, it **does not** imply that there will be coverage when treatment is ultimately rendered. Verification of benefits means that insurance may cover certain treatments such as oral appliances for obstructive sleep apnea or TMJ dysfunction **if the patient has met a level of medical necessity as determined by the insurer**.

- Some insurers allow for **pre-authorization** of services, while others do not allow it. This is at the discretion of the insurer, not our office. Our office is not responsible if the insurer denies coverage after authorization has been made, as we can only make decisions based on the information we are given.

- In the event the insurer does not allow for pre-authorization, treatment must first be rendered and billed to the insurer.

Insurers generally **DO NOT** do the following:

- Guarantee coverage under any circumstances
- Guarantee coverage even after pre-authorization has been given
- Give exact dollar amounts of patient financial responsibility or provider reimbursement

We encourage our patients to contact their insurer if they have any questions.
In the event coverage is denied for any reason, the patient will be financially responsible for all services rendered.

_____ _____

Signature of Patient/Guardian Date

By signing above, you attest that: You have read, understand and agree to the terms of this notice

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY and INITIAL/SIGN BELOW
In consideration of receiving services from "Sherwin Arman, DMD, Inc. dba Center for Facial Pain and Dental Sleep Medicine"; you agree that:

1. _____ **Initial** All services are provided with the understanding that the patient is ultimately responsible for the treatment costs regardless of the insurance coverage, as not all services are a covered benefit with all insurance companies or Medicare.

2. _____ **Initial** Patients must notify this office if they've changed their insurance, have multiple insurance, have become a Medicare recipient or no longer have insurance.

3. _____ **Initial** Patients are responsible for their insurance **co-pays, co-insurances, deductibles and charges not covered by insurance**.

4. _____ **Initial** Cash patients are responsible for full-payment of services rendered at each visit unless other financial arrangements are made.

5. _____ **Initial (BLUE SHIELD PPO PATIENTS ONLY)** Patient understands that our office is **not contracted** with Blue Shield. Therefore, we will collect insurance allowed amount for any services provided at the time services are rendered; Blue Shield sends payment directly to the member.

6. _____ **Initial** Any unpaid balance over 90 days may be turned to an outside collection agency with additional collection agency fees. The patient is responsible for any collection fees incurred in the collections process.

7. _____ **Initial** A charge of $50.00 will be assessed for cancelled visits (and no-show visits) if the office is not notified at least one business day prior to appointment date. These charges are not billable to insurance and are patient's responsibility.

8. _____ **Initial** Returned checks are subject to a $25.00 return check fee.

I authorize "Sherwin Arman, DMD, Inc. dba Center for Facial Pain and Dental Sleep Medicine" to submit claims on my behalf for payment of services rendered to the named insurance company on this form. Furthermore, I authorize "Sherwin Arman, DMD, Inc. dba Center for Facial Pain and Dental Sleep Medicine" to release information relative to my medical history, diagnosis and treatment to the named insurance company if asked to process the claim.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

Center for Facial Pain and Dental Sleep Medicine

Practice Restricted to
Orofacial Pain, Temporomandibular Joint Disorders (TMJ), Related Headaches and Intraoral Appliance Therapy for Sleep Apnea & Snoring

NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth:_____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) this office may use your personal health information for the purpose of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing the consent form. You may request restrictions on the "restriction request" form, which we will provide if needed. You may revoke this consent at any time by signing and dating the revocation form, which we will provide if needed.

ACKNOWLEDGEMENT / CONSENT OF NOTICE OF PRIVACY PRACTICES

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also acknowledge that I am informed of "Sherwin Arman, DMD, Inc. dba Center for Facial Pain and Dental Sleep Medicine's" Practice Privacy Policy and have been offered a copy.

_____ _____
Signature of patient or patient representative Date

AUTHORIZATION FOR RELEASE OF PHI

I _____, hereby give Center for Facial Pain and Dental Sleep Medicine authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

☐ No one but patient

☐ Spouse _____ Cell _____

☐ Mother _____ Cell _____

☐ Father _____ Cell _____

☐ Son(s) _____ Cell _____

☐ Daughter(s) _____ Cell _____

☐ Caregiver _____ Cell _____

☐ Other _____ Cell _____

_____ _____
Signature of patient or patient representative Date

26800 Crown Valley, Pkwy, Suite 405, Mission Viejo, 92691
3300 West Coast Hwy, Suite A, Newport Beach, 92663
Phone: 949-218-3516 * Fax: 949-218-3534 * Email: info@octmjfacepain.com
Website: www.octmjrelief.com

Notice of Privacy Practices

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.

The Health and Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your heath care records for the purpose of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialist's involved n the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a medical and/or dental plan for your medical and/or dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The rights to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorizations.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 as we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal complaint with us at the address below or with the department of health & human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Privacy Officer: Charmaine
Office Name: Center for Facial Pain
and Dental Sleep Medicine
26800 Crown Valley Pkwy, Ste 405
Mission Viejo, CA 92691
Phone: 949-218-3516

For more information or to file complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington D.C. 20201
877-696-6775 (toll free)

(PATIENT'S COPY)