TMJ Patients Packet

Name: ______________________________ Phone: ______________________________

Minnesota Craniofacial Center - Midway
1690 University Avenue West, Suite 390
University Park Medical Center
St. Paul, MN 55104

651.642.1013

Welcome to our practice! ***We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to provide the highest quality care and service to our patients. We take great pride in each staff member's training and capabilities. So that we might all enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies, below:***

APPOINTMENTS: We strive to keep our patient's "waiting time" to a minimum, as we recognize that your time is valuable. Therefore, we are able to see our patients on an appointment basis only (with the exception of emergencies). We consider an appointment made to be an agreement and commitment between our office and our patients, and we rely on our fine patients to abide by their agreement. We reserve the right to reschedule your appointment if you arrive more than 15 minutes past your scheduled appointed time.

EMERGENCIES: As emergencies do arise, we ask your patience and understanding in the event of our having to place an emergency patient in front of your appointment slot. We will try to inform you of any changes necessary ahead of time, if at all possible.

FINANCIAL ARRANGEMENTS: During your first visit, our accounts manager will meet with you. Please direct all inquiries about your account to her rather than to the treatment staff. Our accounts manager will be most happy to discuss how our office handles your insurance benefits, if applicable; how your co-payments (if any) are to be taken care of; how any secondary insurance is handled; and how our office financial policy is administered. She will help you arrange the most suitable method of payment for your care. For your convenience, we accept Visa and Master Card.

INSURANCE: As a courtesy to you, we will be happy to submit all insurance claims for services rendered in our office. However, it is up to you to know if your insurance plan requires a referral or a prior authorization, whether insurance deductibles have been met, if there are plan exclusions for TMJ treatment or dental sleep appliances, what percent of coverage you have, whether you are required to make co-payments and what the co-payment will be, and what your plan maximum coverage is per year. Please see the enclosed form to use when calling your insurance company.

OUR COMMITMENT TO YOU: We appreciate having you as a patient in our practice. We will do everything to deliver the highest quality care in a safe, comfortable and caring environment. Please do not hesitate to ask any questions you might have about our services and office policies. In addition, if you are satisfied with our services, please feel free to tell a friend. We welcome new patients and appreciate referrals of your family and friends.

Very sincerely, Dr. Roy Hakala and Staff

YOUR COMMITMENT TO US: I understand that I am ultimately responsible for my account in this office, regardless of what insurance benefits or other third-party compensation may or may not be applied to my account. I authorize payment of any medical benefits directly to MCCM.

I also consent to the release and retrieval of my personal health information by MCCM to and from my medical and/or any automobile or other insurance companies, and all third parties involved in my care.

I agree to a charge of $50.00 per scheduled hour if I fail or cancel a scheduled appointment **without giving MCCM a 24-hour notice.**

____ ____________________

Patient signature **Date**

Patient Medical & Insurance Information

Please fill out all that apply completely using black or blue pen.

Name: ______________________________________
Date of Birth: ________________________________
Address: ____________________________________
City: _______________________________________
State: _____________ Zip: ____________________
Home #: ____________________________________
Work #: _____________________________________
Cell #: ______________________________________
Employer: ___________________________________
If Minor, Name of Responsible Party:
____
****
Primary Health Insurance: _____________________
Billing Address: ______________________________
City: _______________________________________
State: ____________ Zip: _____________________
Phone #: ____________________________________
Subscriber __________________________________
Subscriber DOB: _____________________________
Policy/Group #: ______________________________
ID # ____
****
Secondary Health Insurance: ___________________
Billing Address: ______________________________
City: _______________________________________
State: _____________ Zip: ____________________
Phone #: ____________________________________
Subscriber: __________________________________
Subscriber DOB: _____________________________
Policy/Group #: ______________________________
ID #: _______________________________________
****
Auto Insurance: ______________________________
Billing Address: ______________________________
City: _______________________________________
State: _____________ Zip: ____________________
DOI: ____________ Claim #: __________________
Adjuster Name: ______________________________
Phone #: ____________________________________
Policy Holder: _______________________________
****
Other Insurance Info (Workers Comp/Personal Injury) Company Name: _______________________
Billing Address: ______________________________
City: _____________ State: _______ Zip: ________
Subscriber: _________________ DOB: _________
Policy#: ______________ID #: _________________

Emergency Contact: ________________________
Phone #: __________________________________
****
Physician: ___________________________________
Clinic Name: _________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****
Dentist: _____________________________________
Clinic Name: _________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****
Chiropractor: ________________________________
Clinic Name: _________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****
Neurologist: _________________________________
Clinic Name: _________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****
Other Care Provider: ___________________________
Clinic Name: _________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****
Attorney: ____________________________________
Contact: _____________________________________
Address: ____________________________________
City: _______________________________________
State: ________________ Zip: _________________
Phone #: ____________________________________
****

Office Use Only

IE Sent: _____________________________________

MN Craniofacial Center Midway, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PLEASE FILL OUT COMPLETELY

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Roy V. Hakala, DDS

Telephone: 651-642-1013 Fax: 651-642-0947

E-mail: info@mncranio.com or drhakala@mncranio.com

Address: 1690 University Avenue West Suite 390 Saint Paul, MN 55104

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: PLEASE PRINT YOUR NAME ON THE LINE, SIGN, AND DATE BELOW

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: ______________ Date: ______________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

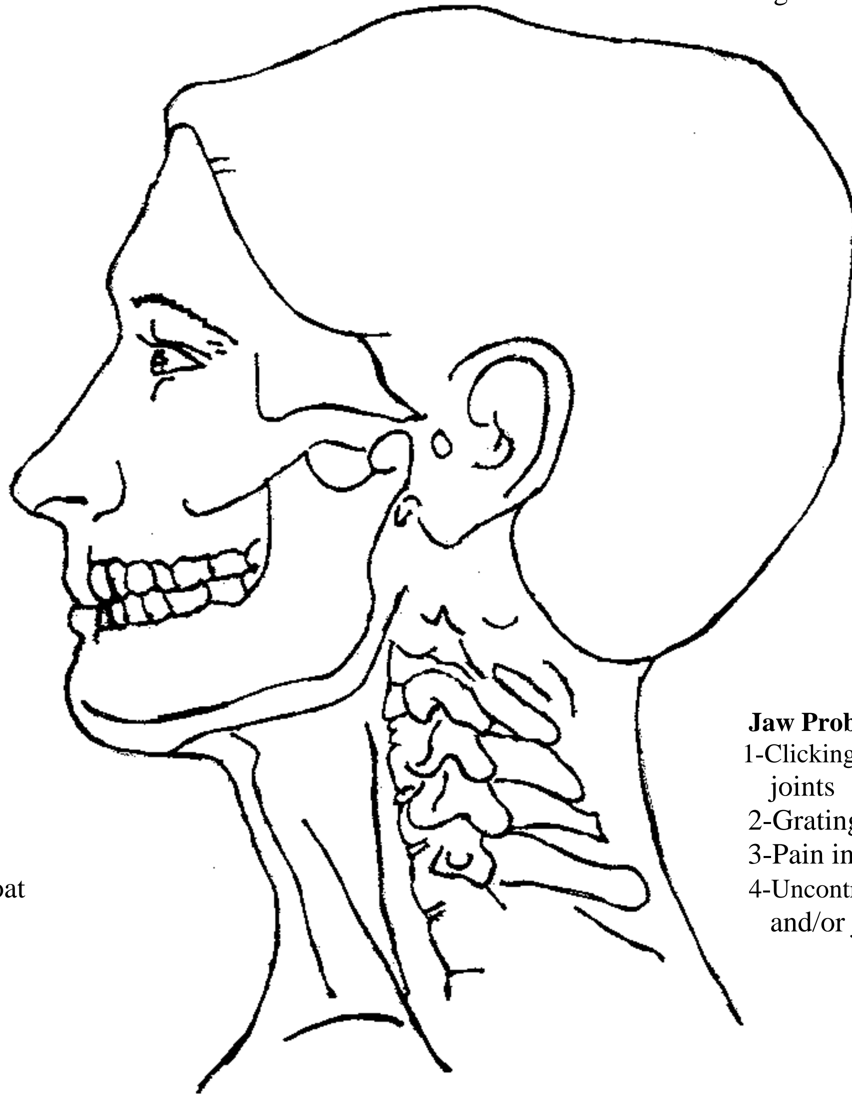
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Please shade the areas of pain on the head diagram and circle the numbers in front of any symptoms you may have. Thank you.

Head Pain/Headaches
1-Forehead
2-Temples
3-"Migraine" type headache
4-Sinus type headache
5-Shooting pain up the back of the head
6-Hair/scalp painful to touch

Ear Problems
1-Hissing, buzzing or ringing
2-Decreased hearing
3-Ear pain/earache with no infection
4-Clogged/itchy ears
5-Vertigo/dizziness

Eyes
1-Pain behind eyes
2-Bloodshot eyes
3-May bulge out
4-Sensitive to light



Mouth
1-Discomfort
2-Limited opening
3-Inability to open smoothly
4-Jaw shifts to one side on opening
5-Jaw locks open or shut
6-Can't find correct bite

Teeth
1-Clenching and/or grinding During the day or night
2-Looseness or soreness of back teeth

Jaw Problems
1-Clicking, popping jaw joints
2-Grating sounds
3-Pain in cheek muscles
4-Uncontrollable tongue and/or jaw movements

Throat Problems
1-Swallowing difficulties
2-Laryngitis
3-Sore throat without infection
4-Frequent cough or clearing of throat
5-Voice irregularities or changes
6-Feeling of foreign object in throat constantly

Neck Problems
1-Lack of mobility
2-Neck pain/stiffness
3-Tired sore muscles
4-Shoulder pain and/or backache
5-Arm and/or finger numbness

Name ____ **Date** ________________

MN Craniofacial Center Midway, P.A. ***Revised 4/07***

Minnesota Craniofacial Center Midway, PA

Welcome to our office! Today you will be given a complete examination of your mouth, head, neck, and jaw. This will include a careful inspection of your teeth, jaw joints, chewing muscles, and your occlusion (bite). Other records such as x-rays, computerized jaw tracking, MRI, and diagnostic models may be necessary to form a complete diagnosis. Please answer as many questions as possible, and write freely on the discussion questions. Some of the material is repetitive, but it is necessary both to help us be thorough and so we may help you obtain any insurance benefits that may apply. Thank you for your help.

Name: ______________________________ Age: _______ Today's Date: ________________

Gender: _____ Male _____ Female

Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Other

Please describe your chief complaints:____

____

____

How long ago did your symptoms start? _____ 0-5 months _____ 6-11 months _____ 1-2 years
_____ 3-5 years _____ 6-10 years _____ 10+ years

Have your symptoms become worse recently? ____

Occupation: ______________________ Typical job duties: ______________________________

Do any of these duties aggravate your condition? ______________________________________

How long have you had your present job? ____

What treatment have you had, or what have you tried to do yourself, to correct your problem? ____________

____

Please discuss the degree of success of your prior treatment. ______________________________

____

Do you have an opinion as to what should be done to solve your problem? ______________________

Do you consider yourself to be under a great deal of stress? _______ If so, please explain: ______________

____

Are your symptoms related to an automobile accident? _______________ If so, date of accident: __________

State where accident occurred: ____________

Are the symptoms related to a work injury? ________________________ If so, date of injury: __________

Name of employer involved: ____

If an accident is involved, did any symptoms exist before the accident? ____________________________

____

Did your symptoms start after any of the following conditions? Please mark all that apply.

Injury to the jaw	_____	Large bite or yawn	_____
Injury to the neck	_____	Raised dental filling	_____
Injury to the head	_____	Dental treatment	_____
Trauma to jaw or head	_____	Excess mouth opening	_____
Severe emotional upset	_____	Orthodontic treatment	_____
Whiplash injury	_____	Cervical traction	_____
Head or neck surgery	_____	Jaw or nose broken	_____

Other____

MEDICAL HISTORY **Do you have or have you ever had any of the following conditions?**

Now	Past	No		Now	Past	No	
_____	_____	_____	Allergies or Asthma	_____	_____	_____	AIDS
_____	_____	_____	Anemia	_____	_____	_____	Arthritis
_____	_____	_____	Eating Disorder	_____	_____	_____	Tuberculosis
_____	_____	_____	Bleeding Problems	_____	_____	_____	Tonsillitis
_____	_____	_____	High Blood Pressure	_____	_____	_____	Low Blood Pressure
_____	_____	_____	Bone Disorder	_____	_____	_____	Cancer
_____	_____	_____	Chronic Pain	_____	_____	_____	Diabetes
_____	_____	_____	Dizziness	_____	_____	_____	Alcoholism or Drug Addiction
_____	_____	_____	Ear Pain	_____	_____	_____	Ear Congestion
_____	_____	_____	Facial Pain	_____	_____	_____	Stomach Problems
_____	_____	_____	Intestinal Problems	_____	_____	_____	Headaches
_____	_____	_____	Heart Disease	_____	_____	_____	Ringing Ears
_____	_____	_____	Hepatitis	_____	_____	_____	Kidney Disease
_____	_____	_____	Neurologic Problems	_____	_____	_____	Psychiatric Condition
_____	_____	_____	Sleep Disturbance	_____	_____	_____	TMJ Pain
_____	_____	_____	TMJ Clicking	_____	_____	_____	TMJ Grating

Please describe any items marked above: ____

____

Do you smoke? ________ If so, how many packs per day? __________________________________

Do you use alcohol? ______ If so, how may drinks per week? ______________________________

Do you use any recreational drugs? ______Describe: ______________________________________

Are you pregnant? ______ If so, expected date of delivery: _________________________________

FAMILY HISTORY Father: Age, if living: _____ His general health: __________________________
Or, age at death: _________ Cause of death: ______________________________

Mother: Age, if living: _____ Her general health: __________________________
Or, age at death: _________ Cause of death: ______________________________

Are there any inherited health conditions or genetic disorders in your family? ____________________

Please specify: ____

____

CURRENT MEDICATIONS	DOSE	CONDITION
____	______________________	FOR____________________
____	______________________	FOR____________________
____	______________________	FOR____________________
____	______________________	FOR____________________

Please list any vitamins or minerals you take. Specify amount: ____
____

Are you allergic to any medications, foods, or latex? ____

Date of last physical exam: _________ Conditions treated: ____

Please list your most serious illnesses and injuries: ____
____

Please list any surgery or hospitalizations you have had: ____
____

Please list your recreational activities. Include any regular exercise that you do: ________________________________
____

Do you play a musical instrument? ____

How many hours are you in bed each night? ____ What is your usual quality of sleep? ___ Good ___ Fair ___ Poor

Are you able to fall asleep quickly? _______ How many times do you wake during a typical night? _____________

Are you able to go right back to sleep if you wake during the night? ________________

Do you hold your breath or gasp during the night? __________________ Do you snore? ______________________

Are you sleepy when you wake up? _________________ Are you often sleepy during the day? ________________

Do you ___ clench ___ grind your teeth? ___ Day or ___ night? ____

Do you often chew your fingernails, or pencils or pens? ____

Have you ever received any kind of TMJ therapy?____

Do you regularly see a chiropractor or physical therapist? ____

Have you ever had orthodontics (braces or retainers)? __________ At what age? ______________________________

If so, were any permanent teeth extracted? _______________ Did you use a headgear? _______________________

Do you still use an orthodontic retainer? ____

What is your height? __________ Your weight? ______

Have you ___ gained or ___ lost weight recently: How much? ________ Over what time? __________

Office Use Only: BP ___________ Pulse __________

Forms Revised 4/07

Insurance Information—Please Read!

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **you** contact your insurance company **prior to your first visit in our office**. We certainly are happy to answer any insurance questions you may have, but please understand, MN Craniofacial Center Midway can only assist you and cannot guarantee payment from your insurance company.

Please call your medical insurance company for the following information:

Non-Surgical TMJ Benefits:

1. Do I have a deductible? Yes or No
2. How much of the deductible has been met? ____________________
3. Do I need a Prior Authorization for:
   A: DME (Durable Medical Equipment)? Yes or No
   (Give DME CODE **D7880** to your insurance representative)
   B: Physical Therapy Yes or No
4. Do I have an office copayment for each visit? Yes or No
5. How much is the office copayment? ________________
6. What percentage of the fee do I pay for the following:
   A. X-Rays: ________________
   B. Office Visits: ________________
   C. DME (Durable Medical Equipment): _______________
   D. Physical Therapy: ___________________

Repair Charges: Repair charges for broken oral appliances are the patient's responsibility to pay and the amount will vary, depending on the type of repair needed. Repair charges are not a covered service by your insurance company.

I have read and I understand my financial responsibility as stated above. I authorize direct payment of benefits from my insurance company to MN Craniofacial Center Midway, P.A.

Signature of Insured, or of Responsible Party if Patient is a Minor:

____ Date: ______________

Witness ____________________________________ Date: ______________