TMJ & Facial Pain Center

Wesley E. Shankland, II, D.D.S., Ph.D., Inc.

158 A Commerce Park Drive ● Westerville, Ohio 43082
614/794-0033 – Office ● 614/794-2291 - Fax

Welcome to Our Office!

We want to welcome you to our office and look forward to serving you! The following information is important in assisting you with planning your first visit to our office. Please feel free to contact us with any questions. Our office hours are: **Monday and Tuesday 7 am to 6 pm and Wednesday 8 am to 2 pm.**

DIRECTIONS and ACCOMMODATIONS A map to our office is enclosed. If traveling from outside Ohio, we are in the Eastern Standard time zone. Several area hotels provide courtesy rates for our patients, and we will provide that information to you.

MEDICAL HISTORY A *Personal History* and *HIPAA Consent form* are enclosed. **Please bring the completed forms to your appointment.** In addition, bring past medical records, x-rays, splints or information you feel is pertinent for your evaluation. Your spouse or partner may accompany you to your appointment as successful treatment begins with family involvement. For their safety and in compliance with state law, *accompanying children are not permitted in the treatment room.*

CANCELLATIONS Kindly consider the time reserved for you. A fee may be charged for failure to show for your appointment. If you need to change or cancel your appointed time, contact us during normal office hours so we can reappoint your time to allow that time for another patient. We regret that appointments missed without notification will not be re-appointed.

INSURANCE TMJ & Facial Pain Center does participate with many insurance plans. Please check with your plan to see if Dr. Shankland is a participating provider. However, many dental plans offer point of service benefits, and you may have coverage to our office outside of your preferred provider plan.

MEDICARE Dr. Shankland **does not** participate with Medicare medical/dental plans. Medicare recipients are required to sign a *private contract form* stating that neither the patient nor the provider will file claims to Medicare for any reason, as stated in the contract. Patient will be responsible for full payment at the time of service, not reimbursable from Medicare.

FEES and PAYMENT PLANS The fees will be determined at the time of the examination and may include, but are not limited to, examination, x-rays, scans, diagnostic injections, treatment or additional procedures that may be performed. We welcome all major credit cards, checks or cash for your convenience. We also offer Care Credit on approval, a flexible payment interest-free or long-term payment options designed for healthcare expenses.

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PATIENT INFORMATION

Today's Date_____

Patient Name: _____, _____
Last First

Address: _____

_____, _____

Home: _____ Cell: _____

Email Address: _____

DOB: _____ SSN: _____/_____/_____

Sex: M / F Married ____ Single____ Other ____

Patient Employer: _____

Spouse's Name_____

DOB: _____ Social Security: _____/_____/_____

Spouse's Phone: _____

Spouse's Employer: _____

_____

Whom may we thank for referring you? _____

EMERGENCY CONTACT: Name: _____

Phone: _____ Relationship: _____

DENTAL INSURANCE

Dental Insurance Company: _____

Address: _____

ID #:_____ Group #:_____

Subscriber: _____ Self___ Spouse___ Child___

Subscriber DOB: _____ SSN:_____/_____/_____

**Please inform staff if you have a secondary dental insurance

Assignment and Release: I certify that I, and/or my dependents, have coverage with the named carrier and benefit assignment to Dr. Wesley Shankland/TMJ & Facial Pain Center, for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.

Dr. Wesley Shankland may use my health care information and may disclose such information to the named carrier and for the purpose of obtaining payment for services. This consent will end when I am no longer a patient of Dr. Wesley Shankland/TMJ & Facial Pain Center.

Confidential Communication: I hereby appoint the following individual as my personal agent_____, (name and relationship to me) to receive: ___ All; or, Only: ___Protected Health Info (HIPAA); ___Appointment times; ___Prescriptions; Test results; ___Copies of medical records; ___Other_____.

Revocation of appointed agent: _____Initial _____Date

Signature/Guardian: _____
Relationship

Patient Consent for Photographs/X-rays/Videos: I consent to photographs, x-rays/videos before, during and after treatment as necessary for the best interest of my health/treatment. These records may also be used in scientific papers and demonstrations. _____Initial for approval

DENTAL INFORMATION / HISTORY

Date of last dental exam: _____ Reason for today's visit: _____

Former Dentist:_____, Address: _____ Phone:_____

Please circle "**Y"** for yes, or "**N"** for no to indicate if you have had any of the following:

Bad breath	Y	N	Loose teeth or broken fillings	Y	N	Clicking or popping of jaw	Y	N
Bleeding gums	Y	N	Mouth breathing	Y	N	Grinding of teeth	Y	N
Blisters on lips/mouth	Y	N	Mouth pain-brushing	Y	N	Jaw pain or tiredness	Y	N
Burning sensation on tongue	Y	N	Periodontal treatment	Y	N	Pain around ear	Y	N
Chew on one side of mouth	Y	N	Sensitivity to cold	Y	N	Orthodontic treatment- have had	Y	N
Cigarette, pipe, or cigar smoking	Y	N	Sensitivity to hot	Y	N	Orthodontic treatment -would like	Y	N
Dry mouth	Y	N	Sensitivity to sweet	Y	N	Do you snore?	Y	N
Fingernail biting	Y	N	Sensitivity when biting/chewing	Y	N			
Food collection between teeth	Y	N	Sores or growths in mouth	Y	N			
Foreign objects	Y	N						
Gums swollen or tender	Y	N	Dental implants	Y	N			
Lip or check biting	Y	N						
How often do you brush per day?				How often do you floss per day?				

HEALTH HISTORY

Primary Care Physician's Name_____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common name for Fosamax, Actonel, Atelvia, Didronel, Boniva. **Yes** **No**

Please circle "**Y"** for yes, or "**N"** for no to indicate if you have had any of the following:

AIDS/HIV	Y	N	Epilepsy	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Fainting or dizziness	Y	N	Respiratory Disease	Y	N
Arthritis, Rheumatism	Y	N	Glaucoma	Y	N	Rheumatic Fever	Y	N
Artificial Heart Values	Y	N	Headaches	Y	N	Scarlet Fever	Y	N
Artificial Joints	Y	N	Heart Murmur	Y	N	Shortness of Breath	Y	N
Asthma	Y	N	Heart Problems: _____	Y	N	Sinus Trouble	Y	N
Back Problems	Y	N	Hepatitis Type _____	Y	N	Skin Rash	Y	N
Bleeding abnormally with extractions or surgery	Y	N	Herpes	Y	N	Special Diet	Y	N
			High Blood Pressure	Y	N	Stroke	Y	N
Blood disease	Y	N	Implants	Y	N	Swollen Feet or Ankles	Y	N
Cancer	Y	N	Jaundice	Y	N	Swollen Neck Glands	Y	N
Chemical Dependency	Y	N	Jaw Pain	Y	N	Thyroid Problems	Y	N
Chemotherapy	Y	N	Kidney Disease	Y	N	Tonsillitis	Y	N
Circulatory problems	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Congenital Heart Lesions	Y	N	Low Blood Pressure	Y	N	Tumor or Growth on head or neck	Y	N
Cortisone Treatments	Y	N	Mitral Valve Prolapse	Y	N	Ulcer	Y	N
Cough, persistent or bloody	Y	N	Nervous Problems	Y	N	Venereal Disease	Y	N
Diabetes	Y	N	Pacemaker	Y	N	Weight Loss, unexplained	Y	N
Emphysema	Y	N	Psychiatric Care	Y	N	Do you wear contact lenses	Y	N
WOMEN: Are you pregnant?	Y	N	Are you nursing?	Y	N	Taking birth control?	Y	N
If so, Due Date:								

PHARMACY NAME: _____ **PHONE:** _____

ADDRESS: _____

MEDICATIONS

List any mediation you are currently taking/diagnosis

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL ALLERGIES

Aspirin	Y	N	Latex	Y	N
Sleeping pills	Y	N	Local Anesthetic	Y	N
Codeine	Y	N	Penicillin	Y	N
Iodine	Y	N	Sulfa	Y	N

Other Allergies_____

_____

_____

Please use this space for any additional information:

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), C.F.R. Parts 160 and 164. The notice of HIPAA policy that you received describes your rights as a patient under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

AUTHORIZATION: By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have a right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- My protected health information may be disclosed or used for treatment or consult, billing, insurance billing, insurance billing or payment or other purposes I may direct.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- This authorization will remain effective unless I revoke this authorization in writing.

YES **NO** May we phone, email or text to confirm appointments?
YES **NO** May we leave a message on your answering machine at home or your cell phone?
YES **NO** May we discuss your medical condition with any family member? If yes, name family members allowed: _____
YES **NO** I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse or other: _____

I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse or other _____, with the exception of the following information: ___ Mental healthcare; ___Communicable disease; ___HIV or AIDS; ___Treatment of Alcohol or Drug Abuse; Other:_____.

I have been given a copy of the HIPAA Policy, have read the HIPAA Privacy Authorization. By signing this form, I consent to your use and disclosure of my protected healthcare information.

_____ _____
Printed name of Patient or Personal Representative Relationship

_____ Date: _____
Signature of Patient or Personal Representative

Notice of Privacy Policies

TMJ & Facial Pain Center, Inc.

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to TMJ & Facial Pain Center, Inc.

TMJ & Facial Pain Center, Inc.'s Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective 04/01/2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated, or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counterintelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you an initial fee of fifteen dollars, one dollar a page for the first ten pages, fifty cents per page for pages eleven through fifty and twenty cents per page for pages fifty-one and higher. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost-based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost-based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Sherry McCutcheon

Practice Name: TMJ & Facial Pain Center

Address: 158 A Commerce Park Drive,
Westerville, Ohio 43082

Phone: 614/794-0033 Fax: 614/794-2291

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Epworth Sleepiness Scale

Please use the following scale to choose the most appropriate number for each situation:

0 = You would never doze
1 = A slight chance of you dozing
2 = A moderate chance of you dozing
3 = A high chance of you dozing

Situation		Scale (0-3)
1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Sitting, inactive in a public place, (e.g. theater, or meeting)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon	_____
6.	Sitting and talking with someone	_____
7.	Sitting quietly after lunch, without alcohol	_____
8.	In a car, while stopped for a few minutes in traffic	_____
	TOTAL:	_____

General Questionnaire

Please answer the following questions by circling either Y (yes) or N (no):

1.	Do you have high blood pressure?	Y	N
2.	Do you have heart disease?	Y	N
3.	Do you have respiratory problems?	Y	N
4.	Do you snore?	Y	N
5.	Do you gasp or choke when sleeping?	Y	N
6.	Are you sleepy during the day?	Y	N
7.	Do you take frequent naps?	Y	N
8.	Do you fall asleep when driving?	Y	N
9.	Do you fall asleep quickly?	Y	N
10.	Do you fall asleep at inappropriate times?	Y	N
11.	Do you have jaw joint (TMJ) pain?	Y	N
12.	Do your jaw joints click or pop?	Y	N
13.	Do your jaw joints lock?	Y	N
14.	Do you have frequent headaches?	Y	N
15.	Do you clench or grind your teeth?	Y	N

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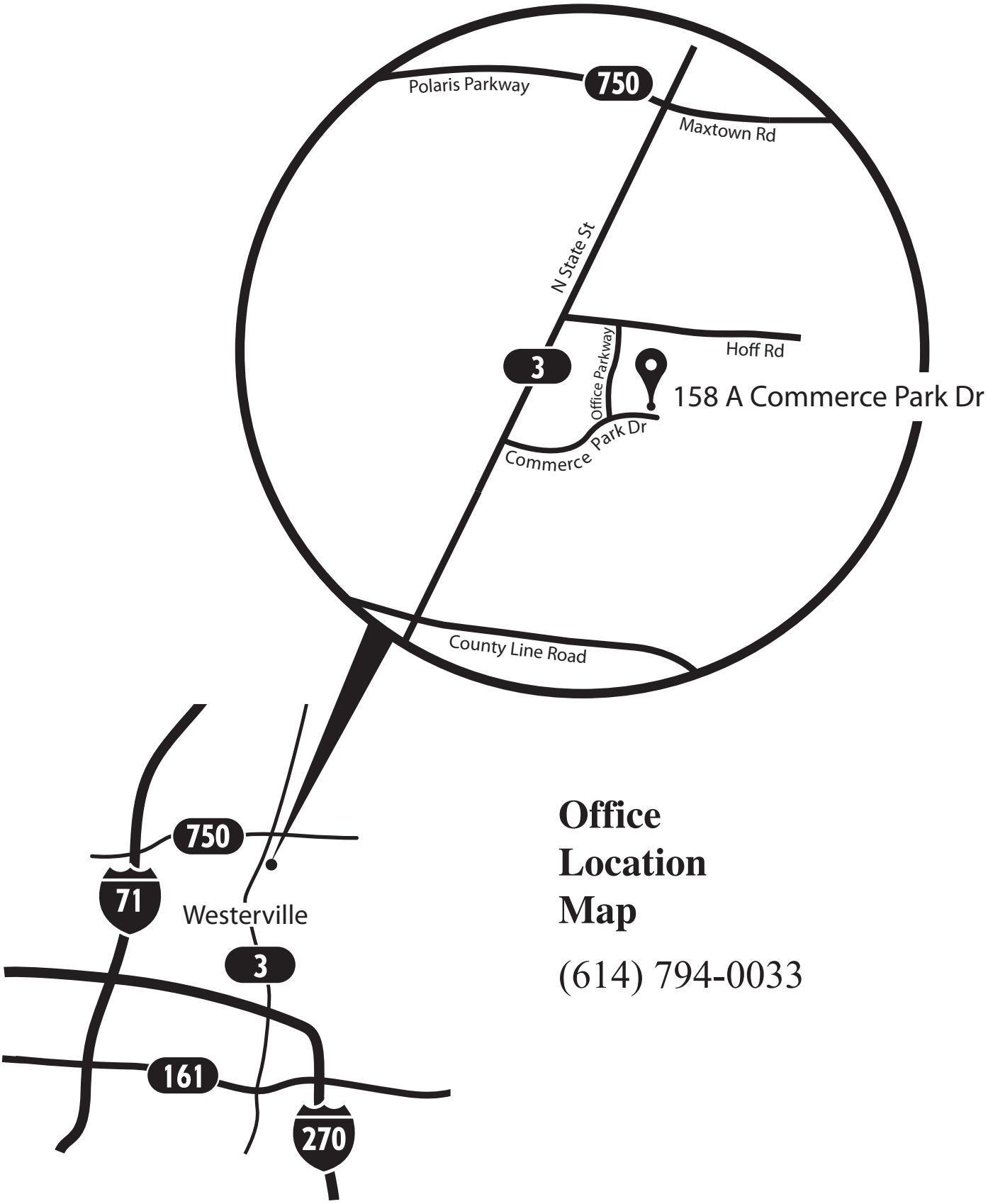

Office Location Map

(614) 794-0033

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