

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 reappointed.

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.

WELCOME LETTER: Dental Welcome Letter 2023

TMJ & Facial Pain Center Wesley E. Shankland, II, D.D.S., M.S., Ph.D.

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Fingernail biting Y N Sensitivity when biting/chewing Y N Sores or growths in mouth Y N Sores or	Fingernail biting Y N Sensitivity when biting/chewing Y N Sores or growths in mouth Y N Sores or	Fingernail biting Y N Sensitivity when biting/chewing Y N Sores or growths in mouth Y N Sores or	DENTAL INFORMATION / Interpretation of last dental exam: Dental Dentist: Dease circle "Y" for yes, or "N" for note that the leeding gums Bleeding gums Blisters on lips/mouth Burning sensation on tongue Chew on one side of mouth	HISTOR no to indicate the second sec	Rate if y	eason for today's visit: , Address: ou have had any of the foll Loose teeth or broken fill Mouth breathing Mouth pain-brushing Periodontal treatment Sensitivity to cold	photog the best scientif	Y Y Y Y	N N N N N	leos before, during and after treatment as nealth/treatment. These records may also emonstrationsInitial for approv Phone: Clicking or popping of jaw Grinding of teeth Jaw pain or tiredness Pain around ear Orthodontic treatment- have had	Y Y Y Y Y
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Gums swollen or tender Y N Dental implants Y N Lip or check biting Y N	Gums swollen or tender Y N Dental implants Y N Lip or check biting Y N	Gums swollen or tender Y N Dental implants Y N Lip or check biting Y N	ate of last dental exam: ormer Dentist: lease circle "Y" for yes, or "N" for n Bad breath Bleeding gums Blisters on lips/mouth Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Dry mouth Fingernail biting	HISTOR To to indicate Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	Rate if y	eason for today's visit:, Address:ou have had any of the foll Loose teeth or broken fill Mouth breathing Mouth pain-brushing Periodontal treatment Sensitivity to cold Sensitivity to hot Sensitivity to sweet Sensitivity when biting/ch	photog the best sciential lowing:	Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	N N N N N N N N	leos before, during and after treatment as nealth/treatment. These records may also emonstrationsInitial for approvementationsPhone:Phone:Phone:Phone:	Y Y Y Y Y Y
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			DENTAL INFORMATION / Interpretation of the process	HISTOR To to indicate the second of the sec	Rate if y N N N N N N N N N N N N N N N N N N N	eason for today's visit: , Address: ou have had any of the foll Loose teeth or broken fill Mouth breathing Mouth pain-brushing Periodontal treatment Sensitivity to cold Sensitivity to hot Sensitivity to sweet Sensitivity when biting/ch Sores or growths in mou	photog the best sciential lowing:	Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	N N N N N N N N N N N N N N N N N N N	leos before, during and after treatment as nealth/treatment. These records may also emonstrationsInitial for approvementationsPhone:Phone:Phone:Phone:	Y Y Y Y Y Y
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			DENTAL INFORMATION / Incomplete the content of the	HISTOR To to indicate the second of the sec	Rate if y N N N N N N N N N N N N N N N N N N N	eason for today's visit:	photog the best sciential lowing:	Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	N N N N N N N N N N N N N N N N N N N	leos before, during and after treatment as nealth/treatment. These records may also be monstrationsInitial for approvements and the monstrations	Y Y Y Y Y Y

HEALTH HISTORY									
rimary Care Physician's Name_					Date	of last visit			
, ,						- 	V N-		
ave you ever used a bisphospho	onate m	iedicatio	on? Common name for Fosama	ax, Actonei, At	eivia, Di	aronei, Boni	/a. Yes No		
ease circle "Y" for yes, or "N" f	or no to	indicate	e if you have had any of the foll	lowing:					
AIDS/HIV	Υ	N	Epilepsy	Y	N	Radiation	Treatment	Υ	N
Anemia	Υ	N	Fainting or dizziness	Y	N		ry Disease	Υ	N
Arthritis, Rheumatism Artificial Heart Values	Y	N N	Glaucoma Headaches	Y	N N	Rheumati Scarlet Fe		Y	N N
Artificial Joints	Y	N	Heart Murmur	Y	N	Shortness	_	Y	N
Asthma	Ÿ	N	Heart Problems:	Y	N	Sinus Tro		Y	N
Back Problems	Υ	N	Hepatitis Type	Y	N	Skin Rash		Υ	N
Bleeding abnormally with	Υ	N	Herpes	Y	Ζ	Special D	et	Υ	N
extractions or surgery		<u> </u>	High Blood Pressure	Y	N	Stroke		Y	N
Blood disease Cancer	Y	N N	Implants Jaundice	Y	N N		eet or Ankles eck Glands	Y	N N
Chemical Dependency	Ϋ́	N	Jaw Pain	Y	N	Thyroid P		Y	N
Chemotherapy	Ý	N	Kidney Disease	Y	N	Tonsillitis	Objective	Ý	N
Circulatory problems	Υ	N	Liver Disease	Y	N	Tuberculo		Υ	N
Congenital Heart Lesions	Y	N	Low Blood Pressure	Y	N		Growth on head or neck	Y	N
Cortisone Treatments Cough, persistent or bloody	Y	N N	Mitral Valve Prolapse Nervous Problems	Y	N N	Ulcer Venereal	Discoss	Y	N N
Diabetes	Y	N	Pacemaker	Y	N		ss, unexplained	Y	N
Emphysema	Y	N	Psychiatric Care	Y	N		ear contact lenses	Y	N
1 7				Y	Ν	Taking bir		Υ	N
NOMEN: Are you preapant?		ı N							
, ,	Y	N	Are you nursing?	1	IN	Taking bii	ui controi?	Ť	IV
f so, Due Date:							III CONIIOI?	T	
MOMEN: Are you pregnant? f so, Due Date: IARMACY NAME: DDRESS:					PHON	IE:		Ť	
f so, Due Date:					PHON			, T	
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ARMACY NAME: DRESS: MEDICATIONS				MEDI Aspirin Sleepir Codein	PHON	ALLERGIE Y Y Y Y Y	N Latex N Local Anesthetic N Penicillin	Y	N N N
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NEW PATIENT: Dental History Form 2023



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

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 appointing	ients?
	YES	NO	May we leave a message on your answering mad	hine at home or your cell phone?
	YES	NO	May we discuss your medical condition with any members allowed:	
	YES	NO	I authorize the release of my complete health re- mental healthcare, communicable diseases, HIV drug abuse or other:	or AIDS, and treatment of alcohol or
commu	inicable eption	e disea of the	ise of my complete health record including records ises, HIV or AIDS, and treatment of alcohol or drug following information: Mental healthcare; _Treatment of Alcohol or Drug Abuse; Other:	g abuse or other, with _Communicable disease;
	ning	this fo	n a copy of the HIPAA Policy, have read the orm, I consent to your use and disclosure	
Print	ed na	me o	f Patient or Personal Representative	Relationship
				Date:
Signa	ture	of Pa	tient or Personal Representative	

HIPAA: Hipaa Privacy Auth Form 10/23

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

HIPAA: Notice of Privacy Policies 2023



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

Epworth Sleepiness Scale

Dloaco uco	the following	scale to shoot	so the most ar	opropriate numbe	r for oad	h cituation:
ricase use	tile following	Scale to Choos	se uie iiiosi al	שטווווטום או ועט ועט ועט	ו וטו כמנ	ii Situatioii.

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

<u>Situat</u>	<u>ion</u>			Scale (<u>)-3)</u>
1.	Sitting and rea	ding			
2.	Watching TV				
3.	Sitting, inactive	e in a public place, (e.g. theater, or mee	ting)		
4.	As a passenge	r in a car for an hour without a break			
5.	Lying down to	rest in the afternoon			
6.	Sitting and talk	king with someone			
7.	Sitting quietly	after lunch, without alcohol			
8.	In a car, while	stopped for a few minutes in traffic			
		то	TAL:		
		General Questionnaire			
	Please answe	r the following questions by circling either Y	(yes) or	N (no):	
	1.	Do you have high blood pressure?	Υ	N	
	2.	Do you have heart disease?	Υ	N	
	3.	Do you have respiratory problems?	Υ	N	
		Do you snore?	Υ	N	
		Do you gasp or choke when sleeping?	Υ	N	
		Are you sleepy during the day?	Υ	N	
		Do you take frequent naps?	Y	N	
		Do you fall asleep when driving?	Y	N	
		Do you fall asleep quickly?	Y	N	
		Do you fall asleep at inappropriate times?	Y	N	
		Do you have jaw joint (TMJ) pain?	Y	N	
		Do your jaw joints click or pop?	Y	N	
		Do your jaw joints lock?	Y	N	
		Do you have frequent headaches?	Y	N	
	15.	Do you clench or grind your teeth?	Υ	N	

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

