Westfield Oral Surgery Associates, P.C.

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HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

TODAY'S DATE _____

PATIENT INFORMATION

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
First Middle Initial Last

Age: _____ Birth Date: _____ ☐ Male ☐ Female

Address: _____ City/State/Zip: _____

Employed By: _____

Address: _____

SS#: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Responsible Party: _____

Family Dentist: _____

Address _____

Family Physician _____

Address _____

Referred By: _____

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____ Insured's Birth date _____

Insured's Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No _____ Group No. _____ I.D. No. _____

If you have additional insurance, please enter the information on the reverse side of this form.

Patient Signature _____ Date _____

Do you have or have you had any of the following complaints?

- ☐ 1. Face or Jaw Pain
- ☐ 2. Jaw noises (clicking, popping, grinding)
- ☐ 3. Jaw catching or locking open
- ☐ 4. Inability to open mouth fully or comfortably
- ☐ 5. Headaches
- ☐ 6. Visual disturbances
- ☐ 7. Eye pain
- ☐ 8. Ear pain
- ☐ 9. Neck soreness
- ☐ 10. Shoulder soreness
- ☐ 11. Sinus problems
- ☐ 12. Tooth pain
- ☐ 13. Ear buzzing
- ☐ 14. Burning mouth/tongue
- ☐ 15. Teeth grinding
- ☐ 16. Snoring

List any medications/substances which have caused an allergic reaction:

_____

_____

_____

_____

List any medications currently being taken:

_____

_____

_____

_____

List any treatments you have had for this problem and all health professionals you are currently seeing:

Practitioner	Specialty	Treatment & approximate date

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

_____

_____

_____

_____

HISTORY OF SYMPTOMS: What do you believe is the cause of your pain or condition? If accident, date

- ☐ Motor vehicle accident
- ☐ Motorcycle accident
- ☐ Work related incident
- ☐ Playground incident
- ☐ Athletic endeavor
- ☐ Fight
- ☐ Fall
- ☐ Accident
- ☐ Illness
- ☐ Injury
- ☐ Unknown
- ☐ Other

FAMILY HISTORY

Have any members of your family (blood kin) had:

- ☐ arthritis
- ☐ migraines
- ☐ headaches

SOCIAL HISTORY

Occupation _____

Do you have children? ☐ Y ☐ N If yes, how many children? _____ What are their ages? _____

☐ Y ☐ N Are you currently under unusual stress?

☐ Y ☐ N Do you chew tobacco?

☐ Y ☐ N Recent changes in lifestyle?

☐ Y ☐ N Do you exercise regularly

Number of caffeine drinks per day _____

☐ Y ☐ N **Do you smoke?**

Number of ☐ Packs ☐ Cigarettes per ☐ Day ☐ Week

Alcohol consumption

☐ Occasional ☐ Social Drinker ☐ Daily ☐ None

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y ☐ N ☐ Adenoids Removed
Y ☐ N ☐ Tonsils Removed
Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Blood pressure High Low
Y ☐ N ☐ Bruising easily
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Cold hands & feet
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Excessive thirst
Y ☐ N ☐ Fluid retention
Y ☐ N ☐ Frequent cough
Y ☐ N ☐ Frequent illnesses
Y ☐ N ☐ Frequent stressful situations
Y ☐ N ☐ General anesthesia
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Gout
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart palpitations
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Injury to:
Y ☐ N ☐ Face Y ☐ N ☐ Neck
Y ☐ N ☐ Mouth Y ☐ N ☐ Teeth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Kidney problems
Y ☐ N ☐ Liver disease
Y ☐ N ☐ Meniere's disease
Y ☐ N ☐ Menstrual cramps
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle aches
Y ☐ N ☐ Muscle shaking (tremors)
Y ☐ N ☐ Other
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Muscular dystrophy
Y ☐ N ☐ Needing extra pillows to help breathing at night
Y ☐ N ☐ Nervous system irritability
Y ☐ N ☐ Nervousness
Y ☐ N ☐ Neuralgia
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Ovarian cysts
Y ☐ N ☐ Parkinson's disease
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Psychiatric care
Y ☐ N ☐ Radiation treatment
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Skin disorder
Y ☐ N ☐ Slow healing sores
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Stroke
Y ☐ N ☐ Swollen, stiff or painful joints
Y ☐ N ☐ Tendency for:
Y ☐ N ☐ Frequent Colds
Y ☐ N ☐ Ear Infections
Y ☐ N ☐ Sore Throats
Y ☐ N ☐ Tired muscles
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Tumors
Y ☐ N ☐ Urinary disorders
Y ☐ N ☐ Wisdom teeth (Third Molar) extraction

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FINANCIAL AGREEMENT AND RESPONSIBILITY

A. I_____, the undersigned, have insurance with _____ _____ (insurance company) and assign directly to Dr. Philip Geron or Westfield Oral Surgery Associates, all benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Deductibles or co-payments, if applicable, must be made at the time of service. If patient overpayment is made based on pre-determination or pre-authorization estimates, patient reimbursement will be made once insurance payments are made.

SIGNATURE:_____DATE:_____

B. FINANCIAL AGREEMENT Please be advised, that Westfield Oral Surgery does not represent any insurance carrier, nor is Westfield Oral surgery responsible for any determinations made by your insurance. Insurance policies are agreements between the patient and the insurance carrier. It is the patient's responsibility to understand their policies and guidelines as to covered and non-covered procedures. I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for services will be provided upon request after examination. If payment cannot be made in full at the time of service, any fees still not paid within 30 days of service will be subject to a 1.5% monthly interest and all legal/collection costs will be the patient's/guardian's responsibility. Once all patient balances are cleared and a patient credit is determined, a refund, if any, can be processed.

SIGNATURE:_____DATE:_____

C. MINOR/CHILD CONSENT I, _____(parent/guardian) being the parent of _____(child's name) do hereby request and authorize the staff to perform the necessary services for my child, including examinations, x-rays, administration of appropriate anesthetics which are deemed advisable by the doctor.

SIGNATURE:_____DATE:_____

D. Westfield Oral Surgery strives to protect your privacy. We are required by law to:

- Maintain the privacy of protected health information
- Give you access to this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect
- A copy of the HIPAA Privacy Policy is available at the front desk for your review.

SIGNATURE:_____DATE:_____