2550 UNIVERSITY AVE WEST
SUITE 143N
ST. PAUL, MN 55114
PHONE (651) 642-1013
FAX (651) 642-0947
mncranio.com

Welcome to the Minnesota Craniofacial Center for TMJ & Sleep Treatment, one of the few clinics nationwide devoted entirely to the treatment of TMJ disorders, head and neck pain, and sleep treatment. We are looking forward to meeting you! Please note 2+ hours have been especially reserved for you. If you cannot keep your appointment please give us at least 24-hours' notice.

Enclosed are several forms. Please fill them out completely and do not leave any spaces blank. If a question does not apply to you, put N/A in for "not applicable." These forms help us to meet your health care needs.

These forms MUST be completed before you can be seen for your appointment. If you arrive without the forms completed, your appointment may need to be rescheduled.

We know that people in pain are uncomfortable sitting for long periods of time, and completed forms will shorten your first appointment. Some of the material is repetitive but it will help us to be thorough and help you receive all appropriate insurance benefits. If you have any questions or difficulty with the forms, please call us at (651) 642-1013. Thank you for your cooperation.

Your first appointment will consist of a thorough examination of your head, jaws, and neck. Since we may need to take radiographic films or perform other tests, we may ask you to remove any jewelry on your head, neck, or face. Spouses or parents of children are encouraged to accompany patients, especially to the initial examination.

Temporomandibular joint disorder/dysfunction is often misunderstood and difficult to diagnose. Possibly you are one of the many people we see who have been told their pain is not real. We will do everything possible to track down the cause of your pain and help you eliminate it.

Sincerely,

The Team at the Minnesota Craniofacial Center for TMJ & Sleep Treatment

Patient Medical & Insurance Information

Please list information for everyone involved in your care. We will send an examination report to each of these addresses, unless you request otherwise. Please use a black or blue pen.

Your Name: _____
Date of Birth: _____
Address: _____
City: _____
State: _____ Zip: _____
Home #: _____
Work #: _____
Cell #: _____
Email: _____
Employer: _____
Emergency Contact: _____
Phone #: _____
****

Whom may we thank for referring you to our office?

_____
****

Primary Health Insurance: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Subscriber: _____
Subscriber DOB: _____
Policy/Group #: _____
ID # _____
****

Secondary Health Insurance: _____
Phone #: _____
Subscriber: _____
Subscriber DOB: _____
Policy/Group #: _____
ID #: _____
****

If your treatment is related to a motor vehicle accident, please fill in the following:

Auto Insurance: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
DOI: _____ Claim #: _____
Adjuster Name: _____
Phone #: _____
****

Attorney: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____

If Minor, Name of Responsible Party:

_____

I authorize sharing my *(check one or both)*
__ financial information / __ treatment information
with the following person:

_____

Signature: _____
****

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 #: _____
****

If your treatment is related to a work injury, please fill in the following:

Other Insurance Info (Workers Comp/Personal Injury) Company Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Subscriber: _____ DOB: _____
Policy#: _____ ID #: _____

History of Presenting Complaints Today's Date:_____

Welcome to our office! Please answer as many questions as possible. 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: _____

Date of birth: _____

Gender: _____Male _____Female _____Other

Please describe your chief complaints or reasons for seeking care:

_____

_____

_____

MEDICAL HISTORY

Do you have a history of any of the following conditions?

Yes	No		Yes	No	
_____	_____	AIDS/HIV+	_____	_____	Arthritis
_____	_____	Bleeding Problems	_____	_____	Bone Disorder
_____	_____	Cancer	_____	_____	Diabetes
_____	_____	Eating Disorder	_____	_____	Heart Disease
_____	_____	Hepatitis	_____	_____	High Blood Pressure
_____	_____	Intestinal Problems	_____	_____	Kidney Disease
_____	_____	Low Blood Pressure	_____	_____	Neurologic Problems
_____	_____	Stomach Problems	_____	_____	Tuberculosis
_____	_____	Respiratory Problems	_____	_____	Mental Health Concerns

Please describe any items marked above or list conditions not mentioned:

_____

_____

_____

Tobacco Use: Do you smoke?_____ vape?_____chew?_____

How often?_____packs/day or _____times per _____

Have you smoked in the past? _____ yes _____ no Quit date:_____

Do you use beer, wine, or other alcoholic beverages? __yes __no

If so, how many drinks per week? ___0-3 ___4-10 ___more than 10

Do you use any recreational drugs? __yes __no

Describe: _____

Are you pregnant? ____yes ____no If so, expected date of delivery: _____

FAMILY HISTORY, IF KNOWN:

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?

_____Yes _____ No _____Unknown

Please specify:

_____

CURRENT MEDICATIONS or attach list DOSE CONDITION

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

Please list any vitamins, minerals, or other supplements you take. Specify amount:

_____

_____

Are you allergic to any medications, foods, or latex? ____Yes _____No

If yes, please specify:

_____

Do you have any environmental allergies?_____Yes_____No

If yes, please specify_____

Approx. date of last physical exam (month & year): _____

Conditions treated:

_____

_____

Please list any surgery or hospitalizations you have had:

_____

_____

Please list any regular exercise that you do:_____

_____

1. Have you been told you snore? ____Yes ____No___Unsure
2. If yes, how long have you been aware of your snoring? _____
3. If you snore, has this caused problems for friends or relatives? _____
4. Have you been told your breathing stops while asleep? _____
5. Do you usually sleep on your back, side or stomach?_____
6. Have you been told you move around a lot in your sleep? _____
7. Do you have any difficulty falling asleep at night?_____
8. Are you aware of any abnormal sleep behaviors, such as sleepwalking? _____
9. Do you have any family members with sleep breathing problems?_____
10. How many hours of sleep per night do you get? _____
11. Do you wake during the night?____ If so how many times? _____
12. Do you usually wake feeling refreshed in the morning?_____
13. Do you often wake with a headache? _____
14. Will a small amount of alcohol give you a hangover? _____
15. Do you feel sleepy during the day ___frequently ___occasionally ___never
16. Have you ever fallen asleep while driving? _____
17. Have you had an overnight sleep study done?_____ If so, when? _____
    Results of study? _____
18. If diagnosed with a sleep breathing disorder (including apnea), what treatment have you had, and how successful has it been?_____
    _____
19. Do you have trouble breathing through your nose?_____
20. Do you clench or grind your teeth during the ___ day or ___ night or _____ both?
21. Do you often chew ___ fingernails, ___ pencils or pens, or ___ other?

22. Do you regularly see a chiropractor or physical therapist? If so, how often?

    _____

23. Have you ever had orthodontics (braces or retainers)? _____ At what age? _____
24. If so, were any permanent teeth extracted? _____Did you use a headgear? _____

    Was expansion done?_____Do you still use an orthodontic retainer?_____

    Is the retainer removable?_____
25. Have you ___ gained or ___ lost weight recently?

    How much? _____ Over what time? _____
26. Is there anything else you would like us to know?_____

    _____

    _____

    _____

THE EPWORTH SLEEPINESS SCALE
AND STOP BANG QUESTIONNAIRE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how they are likely to affect you. Use the following scale to choose the most appropriate number for each situation, and write the number in the blank:

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation:	**Chance of Dozing:**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place such as a theater or a meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL POINTS:	

Please check all that apply:

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors?	
Do you feel TIRED, fatigued, or sleepy during the daytime?	
Has anyone OBSERVED you stop breathing during sleep?	
Do you have, or are you being treated for high blood PRESSURE?	
BMI higher than 35kg/m2?	
AGE over 50 years?	
NECK circumference >16 inches (40cm)?	
Is your GENDER male?	
TOTAL CHECKED:	

Patient Name:
DOB:

IF YOU HAVE TMJ OR PAIN CONCERNS, PLEASE ANSWER THE FOLLOWING:

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?

_____

Do you have an opinion about what caused your current symptoms?

_____

Have you ever experienced a fall or any type of injury to your head, neck, or jaw?

_____

Who have you consulted about your condition?

_____

What were their treatments or recommendations?

_____

What dietary, nutritional or lifestyle changes have you made?

_____

What else have you tried yourself to correct the 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?

_____

_____

Have you ever had any kind of TMJ (jaw joint) therapy or surgery?_____ If so please describe and give dates_____

Do you play a musical instrument? _____Yes _____No Please specify:_____

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

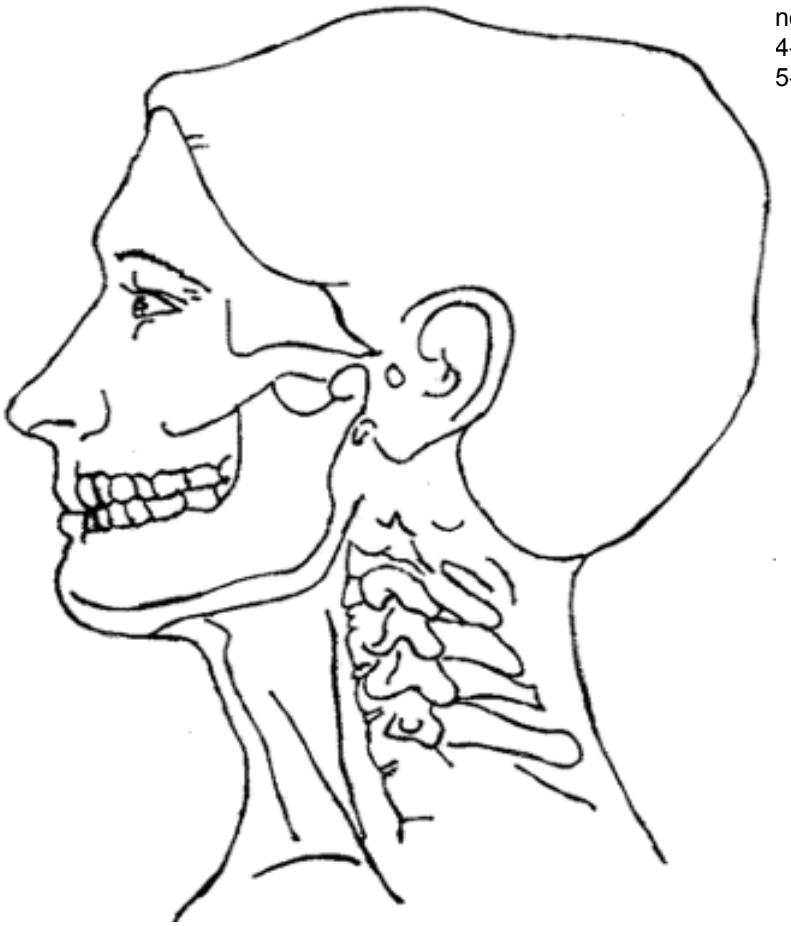
Eyes
1-Pain behind eyes
2-Bloodshot eyes
3-May bulge out
4-Sensitive to light

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

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

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-Tire sore muscles
4-Shoulder pain and/or backache
5-Arm and/or finger numbness



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

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

Patient Name:
DOB:

PATIENT HEALTH QUESTIONNAIRE
(PHQ-9)

We at the Minnesota Craniofacial Center are concerned with the general wellbeing of our patients, and factors such as environmental stressors, lifestyle, and nutrition can play a part in your overall health and speed of recovery. As our goal is to provide you with the best care possible, we ask that you complete the questions below.

Over the last 2 weeks how often have you been bothered by any of the following?

	None	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed, or hopeless?	0	1	2	3
3) Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

= Total Score: _____

GAD-7

Over the <u>last 2 weeks</u> how often have you been bothered by any of the following?

	None	Several days	More than half the days	Nearly every day
1) Feeling nervous, anxious, or on edge	0	1	2	3
2) Not being able to stop or control worrying	0	1	2	3
3) Worrying too much about different things	0	1	2	3
4) Trouble relaxing	0	1	2	3
5) Being so restless that it is hard to sit still	0	1	2	3
6) Becoming easily annoyed or irritable	0	1	2	3
7) Feeling afraid, as if something awful might happen	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

= Total Score: _____

Disorders of the TMJ and pain go hand in hand. Long-term, or chronic, pain can sometimes contribute to effects such as depression, anxiety, and decreased quality of life. The psychological effect from pain in turn can exacerbate the chronic pain.

We are very optimistic that once function is restored and balance is achieved through treatment with us that the pain will resolve or become manageable. However, chronic pain can sometimes cause such a disturbance that restoring balance and function and removing the source of the physical pain is not enough, and this may need to be addressed specifically. If we feel that the effects of chronic pain are inhibiting your treatment with us, we may recommend that you consider seeing someone such as a pain psychologist. If you would prefer a referral now, please let us know.

PEDIATRIC SLEEP QUESTIONNAIRE

Fill out this form if you are a parent or guardian accompanying a child receiving treatment. Please complete it as accurately as possible. In our practice we are very interested in our patients' overall health, and orthodontic treatment in children can be an important part of managing health problems caused by sleep and breathing disorders.

Patient's name: _____ Age: _____

Form filled out by: _____

While sleeping does your child...	Yes	No	Don't Know
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever...			
Seen your child stop breathing during the night?			
Does your child...			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often...			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others (e.g., butts into conversations or games)			

Total Number of "Yes" Responses _____

CHERVINE ET AL, PEDIATRIC SLEEP QUESTIONNAIRE: VALIDITY AND RELIABILITY OF SCALES FOR SLEEP DISORDERED BREATHING, SNORING, SLEEPINESS, AND BEHAVIORAL PROBLEMS, SLEEP MEDICINE 2000;1:21-32

Patient Name:
DOB:

MN Craniofacial Center, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PLEASE FILL OUT COMPLETELY

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient 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. Kim M Ledermann, DDS

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

E-mail: info@mncranio.com

Address: 2550 University Avenue West #143N, Saint Paul, MN 55114

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 healthcare 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.

Patient Name:
DOB:

MINNESOTA
CRANIOFACIAL
CENTER, P.C.

Practice policies

We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to providing 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:

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 patient care manager will meet with you. Please direct all inquiries about your account to her rather than to the treatment staff. Our patient care manager or billing specialist 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 Mastercard.

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.

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 MCC. If my insurance denies coverage for my treatment and an appeal is necessary, I will be expected to pay my balance due within 30 days of receiving the denial. If, after the appeal, my insurance does issue payment to MCC, then MCC will issue me a refund.

I also consent to the release and retrieval of my personal health information by MCC 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 if I fail or $25 if I cancel a scheduled appointment **without giving MCC a 24-hour notice.**

_____ _____

Patient signature **Date**

Patient Name:
DOB: