



Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- \* A basis for planning my care and treatment
\* A means of communication among the many health professionals who contribute to my care
\* A source of information for applying my diagnosis and surgical information to my bill
\* A means by which a third-party payer can verify that services billed were actually provided, and
\* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information used and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

For office use only

- [ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_
[ ] Consent refused by patient, and treatment refused as permitted
[ ] Consent added to the patient's medical record on \_\_\_\_\_

MICHIGAN HEAD & NECK INSTITUTE

PATIENT INFORMATION

Last Name: First Name: Middle Initial: Age:
Address:
City: State: Zip:
Home Telephone: Birth date: Social Security No:
[] Male [] Female [] Married [] Widowed [] Divorced [] Single
Family Physician: Phone no:
Family Dentist: Phone no:
When was your last dental appointment?
Emergency contact person: Phone no:
Relationship of emergency contact person:

EMPLOYMENT INFORMATION

Employer Name: Phone no:
Employer Address: Your Job title:
Are you presently working? [] Yes [] No If no, when was your last day worked?
Have you missed any work due to your present condition? (Please give dates)
The most difficult tasks while at work are/were

INSURANCE INFORMATION

Primary Health Insurance {Complete even if you are covered by auto insurance} Policy Holder SS# / /
Insured: D.O.B.: Relationship:
Insurance Co: Phone:
Billing Address:
City: State: Zip:
Policy/Contract No: Group no:

Secondary Health Insurance {Complete even if you are covered by auto insurance} Policy Holder SS# / /
Insured: D.O.B.: Relationship:
Insurance Co: Phone:
Billing Address:
City: State: Zip:
Policy/Contract No: Group no:

Auto Insurance {Complete only if injury is result of an auto accident}
Insured: D.O.B.: Relationship:
Insurance Co: Phone no:
Address:
City: State: Zip: Has this been reported? [] Yes [] No
Claim No: Adjuster: Date of injury:

Workers Compensation {Complete only if injury is result of a work related incident}
Employer: Date of Accident:
Address:
City: State: Zip:
Has this been reported? [] Yes [] No If yes was treatment authorized? [] Yes [] No
Insurance Co: Phone no:
Address:
City: State: Zip:
Adjuster: Claim No:

Dental Insurance {Complete even if you are covered by auto insurance} Policy Holder SS# / /
Insured: D.O.B.: Relationship:
Insurance Co: Phone:
Address:
City: State: Zip:
Group no: Policy no: Contract no:

Patient Signature: Date:

**MEDICAL HISTORY**

Please check the following conditions that apply to your medical history

**ALLERGIES**

- Hay fever
- Allergic to: (please list medications or other)

\_\_\_\_\_

**ARTHRITIS**

- Gout
- Osteoarthritis
- Rheumatoid Arthritis
- Other: \_\_\_\_\_

**ENDOCRINE DISORDERS**

- Diabetes
- Hypoglycemia
- Parathyroid Disease
- Thyroid Disease
- Other: \_\_\_\_\_

**EYE DISORDERS**

- Glaucoma
- Ocular Herpes
- Other: \_\_\_\_\_

**HIV DISORDERS**

- AIDS
- ARC
- Tested HIV positive
- Other: \_\_\_\_\_

**KIDNEY/URINARY DISORDERS**

- Bladder Infections
- Blood in Urine
- Kidney Disease
- Sugar in Urine
- Other: \_\_\_\_\_

**MUSCLE DISORDERS**

- Muscular Dystrophy
- Other: \_\_\_\_\_

**NERVE DISORDERS**

- Cerebral Palsy
- Epilepsy
- Neuralgia
- Multiple Sclerosis
- Parkinson's Disease
- Stroke
- Other: \_\_\_\_\_

**ARTIFICIAL IMPLANTS**

- Heart Pacemaker
- Heart Valve
- Joint Prosthesis
- Other: \_\_\_\_\_

**BLOOD DISORDERS**

- Anemia
- Bleeding Easily
- Hemophilia
- Leukemia
- Sickle Cell Anemia
- Other: \_\_\_\_\_

**HEART/CIRCULATORY DISORDERS**

- Arteriosclerosis
- Congenital Heart Disorders (at birth)
- Coronary Artery Disease
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Rheumatic Fever
- Other: \_\_\_\_\_

**LIVER DISEASE**

- Cirrhosis of the liver
- Hepatitis A (Infectious)
- Hepatitis B (Serum)

**LUNG/RESPIRATORY DISORDERS**

- Asthma
- Chronic Colds
- Emphysema
- Frequent Cough
- Lung Cancer
- Shortness of Breath
- Tuberculosis
- Other: \_\_\_\_\_

**STOMACH/INTESTINAL DISORDERS**

- Colitis
- Ulcers
- Other: \_\_\_\_\_

**OTHER MEDICAL CONDITIONS**

- Addiction to alcohol
- Addiction to drugs
- Bruising easily
- Chemotherapy
- Chronic fatigue
- Excessive Thirst
- Frequent stressful situations
- Nervousness
- Osteoporosis
- Psychiatric care
- Radiation Treatment
- Scarlet Fever
- Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS**

Please list all medications (prescribed or over the counter), vitamins, or herbal remedies you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check the following symptoms that apply to your condition

**SYMPTOMS**

Do you get headaches?  Yes  No

HEAD PAIN Location	What Side			Pain Level			How often do you get the pain			Duration (how long does your pain last)				
	Right	Left	Both	Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
Front of your head														
Entire Head														
Top of your head														
Back of your head														
In your temples														

Do you have facial pain?  Yes  No

FACIAL PAIN Location	Pain Level			How often do you get the pain			Duration (how long does your pain last)						
	Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks		
Left Side													
Right Side													
Both Sides													

Do you have jaw pain?  Yes  No

JAW PAIN	Right	Left	Both	Neither		Right	Left	Both	Neither
	On Opening						At Rest		
On Wide Opening					Jaw Popping & Grinding				
On side to side movement					Jaw Clicking on Opening				
On Closing					Jaw Clicking on Closing				
While Chewing									

Please circle what applies to your jaw problem

**JAW PROBLEMS**

On Opening jaw moves to the	Right	Left
Cannot move jaw to	Right	Left
Jaw Locks	Open	Closed

**EYE RELATED CONDITIONS**

- Blurred Vision
- Double Vision
- Swelling below eyes
- Pain in eye ( Right  Left)
- Pain or pressure behind eyes
- Photophobia (extreme sensitivity to light)
- Lacrimation (excessive watering)
- Other: \_\_\_\_\_

**EAR RELATED CONDITIONS**

- Buzzing in the ears
- Dizziness
- Hearing loss
- Recurrent infections
- Sensitivity to some sounds
- Congestion/Stuffiness
- Earache:  Right  Left  Both
- Pain in front of the ear:  Right  Left  Both
- Pain behind the ear:  Right  Left  Both
- Tinnitus (ringing or roaring in ear):  Right  Left  Both

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OTHER RELATED CONDITIONS**

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- |   |   |
|---|---|
| <input type="checkbox"/> Back pain (lower)  | <input type="checkbox"/> Constant sore throat     |
| <input type="checkbox"/> Back pain (upper)  | <input type="checkbox"/> Difficulty in swallowing |
| <input type="checkbox"/> Back pain radiating to the neck  | <input type="checkbox"/> Swelling in the neck     |
| <input type="checkbox"/> Shoulder pain  | <input type="checkbox"/> Swollen glands           |
| <input type="checkbox"/> Neck pain  | <input type="checkbox"/> Swollen lymph nodes      |
| <input type="checkbox"/> Limited movement of the neck   | <input type="checkbox"/> Thyroid enlargement      |
| <input type="checkbox"/> Stiffness in neck  | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Numbness or tingling in the hand or fingers <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |   |

**MOUTH AND NOSE RELATED CONDITIONS**

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- |   |   |
|---|---|
| <input type="checkbox"/> Chronic Sinusitis            | <input type="checkbox"/> Dry mouth  |
| <input type="checkbox"/> Frequent biting of the cheek | <input type="checkbox"/> Broken teeth   |
| <input type="checkbox"/> Frequent biting of the lip   | <input type="checkbox"/> Sensitive or sore teeth <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Burning tongue               | <input type="checkbox"/> Numbness, Where? _____   |
| <input type="checkbox"/> Do you snore?                | <input type="checkbox"/> Tired during the day   |
| <input type="checkbox"/> Other: _____                 |   |

**EMOTIONAL CONDITIONS**

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- |  |  |
|--|--|
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Insomnia (difficulty sleeping)        |
| <input type="checkbox"/> Irritability          | <input type="checkbox"/> Relationship changes                  |
| <input type="checkbox"/> Fear and/or avoidance | <input type="checkbox"/> Diminished libido (lowered sex drive) |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Argumentative                         |
| <input type="checkbox"/> Crying for no reason  | <input type="checkbox"/> Panic attacks                         |
| <input type="checkbox"/> Mood swings           | <input type="checkbox"/> Change in personality                 |
| <input type="checkbox"/> Nightmares            | <input type="checkbox"/> Fear of driving                       |
| <input type="checkbox"/> Fear of: _____        | <input type="checkbox"/> Other: _____                          |

**COGNITIVE CONDITIONS**

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- |   |   |
|---|---|
| <input type="checkbox"/> Difficulty expressing myself             | <input type="checkbox"/> Difficulty starting new tasks          |
| <input type="checkbox"/> Confusion                                | <input type="checkbox"/> Difficulty completing tasks            |
| <input type="checkbox"/> Disorientation to person, place, or time | <input type="checkbox"/> Difficulty understanding what you hear |
| <input type="checkbox"/> Memory difficulty                        | <input type="checkbox"/> Difficulty understanding what you read |
| <input type="checkbox"/> Difficulty with map directions           | <input type="checkbox"/> Decreased organization                 |
| <input type="checkbox"/> Difficulty finding the right word        | <input type="checkbox"/> Difficulty with speech                 |
| <input type="checkbox"/> Difficulty concentrating                 | <input type="checkbox"/> Difficulty with attention              |

What makes your pain worse? \_\_\_\_\_

What do you believe is the cause of your pain or condition?

- |   |
|---|
| <input type="checkbox"/> An automobile accident (Date: _____)   |
| <input type="checkbox"/> A motorcycle accident (Date: _____)    |
| <input type="checkbox"/> A work-related accident (Date: _____)  |
| <input type="checkbox"/> A slip and fall accident (Date: _____) |
| <input type="checkbox"/> Other: _____                           |

What other information is important to your condition?

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

What are the chief complaints for which you are seeking treatment?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

What treatment if any, have you had for this problem? Please list the doctor(s) name and phone number(s) that performed this treatment.

\_\_\_\_\_

\_\_\_\_\_

What helps your condition?

\_\_\_\_\_

What makes it worse?

\_\_\_\_\_

Are you able to perform normal household activities?  Yes  No

Are you incapacitated?  Yes  No

Have you ever had any symptoms of a TMJ disorder?  Yes  No

Has a physician or dentist ever diagnosed you with a TMJ disorder?  Yes  No

If a physician or dentist ever diagnosed you with a TMJ disorder, please list their name, phone number, and what year you were diagnosed for this condition.

Physician or Dentist	Phone	Date of Diagnosis

**ACCIDENT INFORMATION**

(Please fill out **only** if you were involved in an accident)

Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_

- Were you a passenger in a vehicle?  Did you fall?
- Were you the driver of a vehicle?  Did an object hit you?
- Were you a pedestrian?  Did you hit an object?
- Were you at work?  Other: \_\_\_\_\_

If you were in a vehicle, where was the vehicle hit?

- At front end  On the driver's side
- At rear end  On passenger's side
- Head on  Other: \_\_\_\_\_

Were you wearing your seat belt?  Yes  No

Was anyone else hurt in the accident?  Yes  No

If yes, please list names of others involved and their relationship to you: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INDICATE IF THERE WAS ANY DIRECT TRAUMA**

Did you hit your head?  Yes  No If yes, please check the following that apply

	Steering wheel	Windshield	Passenger's side window	Driver's side window	Headrest	Seat	Roof	Other
Forehead								
Face								
Chin								
Right side of head								
Left side of head								
Back of head								
Top of head								
Teeth								
Jaw								
Other								

Were any areas of your body painful shortly after the accident/incident?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Head           | <input type="checkbox"/> Left arm     |
| <input type="checkbox"/> Neck           | <input type="checkbox"/> Right arm    |
| <input type="checkbox"/> Face           | <input type="checkbox"/> Lower back   |
| <input type="checkbox"/> Jaw            | <input type="checkbox"/> Upper back   |
| <input type="checkbox"/> Left shoulder  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Right shoulder |                                       |

Please describe your accident/incident:

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Did you lose consciousness?  Yes  No, If yes, how long? \_\_\_\_\_

Were you dizzy or confused?  Yes  No

Did you go to the hospital?  Yes  No

If yes, how did you get there?  By car  By ambulance  Other \_\_\_\_\_

If taken by ambulance did they use  a Backboard, or  Neck brace?

Name of hospital taken to: \_\_\_\_\_

How long were you hospitalized for? \_\_\_\_\_

Were you cited with a traffic violation?  Yes  No

Was the driver of the vehicle in which you were a passenger cited with a traffic violation?  Yes  No

Was the driver of the other vehicle cited with a traffic violation?  Yes  No

**If you have had a previous accident(s) or incident(s) please fill out the following:**

Please list the date and a detailed description of your accident(s): \_\_\_\_\_

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Name(s), address(s), and phone number(s) of hospital and/or doctors where you were treated for this previous accident or incident: \_\_\_\_\_

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I attest that the information provided is complete and accurate to the best of my ability.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent heavy snoring                                 | <input type="checkbox"/> Morning hoarseness         |
| <input type="checkbox"/> _____ which affects the sleep of others                | <input type="checkbox"/> Morning headaches          |
| <input type="checkbox"/> Significant daytime drowsiness                         | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> I have been told that "I stop breathing" when sleeping | <input type="checkbox"/> Nocturnal teeth grinding   |
| <input type="checkbox"/> Difficulty falling asleep                              | <input type="checkbox"/> Jaw pain                   |
| <input type="checkbox"/> Gasping when waking up                                 | <input type="checkbox"/> Facial pain                |
| <input type="checkbox"/> Nighttime choking spells                               | <input type="checkbox"/> Jaw clicking               |
| <input type="checkbox"/> Feeling unrefreshed in the morning                     |   |

Other: \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:

0	1	2	3
No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

	0	1	2	3
	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. 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				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had an evaluation at a Sleep Center Yes \_\_\_ No \_\_\_

If Yes:

Sleep Center Name \_\_\_\_\_  
And location \_\_\_\_\_

Sleep Study Date \_\_\_\_\_

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The evaluation confirmed a diagnosis of: Mild \_\_\_\_, Moderate \_\_\_\_, Severe \_\_\_\_, obstructive sleep apnea

The evaluation showed an RDI of \_\_\_\_\_ and an AHI of \_\_\_\_\_

**CPAP Intolerance (Continuous Positive Airway Pressure device)**

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- \_\_\_ mask leaks
- \_\_\_ I was unable to get the mask to fit properly
- \_\_\_ discomfort caused by the straps and headgear
- \_\_\_ disturbed on interrupted sleep caused by the presence of the device
- \_\_\_ noise from the device disturbing my sleep and/or bed partner's sleep
- \_\_\_ CPAP restricted movements during sleep
- \_\_\_ CPAP does not seem to be effective
- \_\_\_ pressure on the upper lip causing tooth related problems
- \_\_\_ of a latex allergy
- \_\_\_ claustrophobic associations
- \_\_\_ an unconscious need to remove the CPAP apparatus at night

Other: \_\_\_\_\_

**OTHER THERAPY ATTEMPTS**

What other therapies have you had for breathing disorders?  
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?  
\_\_\_ Never \_\_\_ Once a week \_\_\_ Several days a week \_\_\_ Daily

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?  
\_\_\_ Never \_\_\_ Once a week \_\_\_ Several days a week \_\_\_ Daily

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?  
\_\_\_ Never \_\_\_ Once a week \_\_\_ Several days a week \_\_\_ Daily

Tobacco consumption: \_\_\_ Non -Smoker \_\_\_ Smoker \_\_\_ number of packs per day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**It may be important for us to communicate our recommendations for you with other doctors. Please list all of the names and addresses of doctors that you are currently seeing, even if it is not for pain.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N