

NOVA Orofacial Pain, TMD & Dental Sleep Medicine
8987 Hersand Dr.
Burke, Virginia 2205
703-389-0111 Fax: 703-991-1177

BILLING PROCEDURES

We welcome you to our practice as either a new patient or returning patient and would like to briefly review or update you on our billing procedures.

1. Currently, we participate with only Tricare (authorized non network), and Medicare. We do not participate with any dental insurance plans.
2. If you do not have one of the above insurance plans, our office will work with you to obtain reimbursement and send claim forms to your insurance company, but you are responsible for all charges.
3. If you have Medicare, to obtain coverage you will have to meet certain Medicare mandated requirements and provide all necessary paperwork prior to your initial visit. You might have to pay a small portion if your secondary insurance does not cover a particular service. Some procedures are not covered under Medicare, and you will need to sign an ABN form and make payments.
4. All patients need to understand that if their insurance does not cover a service that they are responsible for any balance. *Please Note: If your insurance does not reimburse the Practice after two claim submissions, patient will be responsible for the remaining balance.* For your convenience we accept VISA, MasterCard, AMEX, Discover, checks, and cash. Payments are due at the time of treatment.
5. All fees and charges are due on the date of service. In the event the practice proceeds with collections any monies due over 90 days from the date of presentation of an invoice, will be the full responsibility of the patient. All attorney fees and any other costs incurred by the practice will be the responsibility of the patient.

I have read the above and accept financial responsibility for services rendered.

Patient/Guardian Signature

Date

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Burke, VA 22015

HEAD AND NECK PAIN EVALUATION FORM

Date: _____ Name: _____

Date of Birth: _____ Age: ____ Height: ____ Weight: ____

Address: _____ City & State: _____ Zip Code: _____

Mobile: _____ Other Phone # _____ H - W (circle one)

Email: _____

Medical Insurance: _____ Dental Insurance: _____

I. Referring Doctor and other Doctors you would like to have reports sent to;

Name of Doctor	Specialty	Phone Number	Fax Number	Address

II. Understanding Your Pain

A. Describe in ***your own words*** the problem(s) you would like help with:

B. Is nausea associated with your pain? Yes ___ No ___

Is vomiting associated with your pain? Yes ___ No ___

Does your pain increase with bright lights? Yes ___ No ___

Does your pain increase with loud noises? Yes ___ No ___

Does physical activity make your pain: Better worse no change (circle one)

Do you get an aura? (flashing lights, zigzags, blindness, smells)? Yes ___ No ___ If yes describe: _____

Does your pain wake you up from sleep? Yes ___ No ___

Does your pain keep you from falling asleep? Yes ___ No ___

Do any of your family members have the same or similar pain problems? Yes ___ No ___

Do any of these occur with your pain (circle all that apply):

Eye lid drooping Redness of the eye(s) Tearing of the eye(s) Nasal stuffiness Face sweating

Do you have difficulty opening or closing your mouth? Yes ___ No ___

Do you hear clicking or popping in your jaw points? Yes___ No___

C. Is your pain Continuous or Intermittent?

If your pain is intermittent how often does it occur?

- Several times a day
- Once per day
- Several times per week
- Once per week
- Less than once per week
- Never
- Other

D. How long does your pain last?

- None
- Seconds
- Minutes
- Hours
- Days
- Weeks
- Continuous

E. Circle a number below to indicate your **highest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

F. Circle a number below to indicate your **lowest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

G. Circle a number below to indicate your **usual** pain intensity over the past week

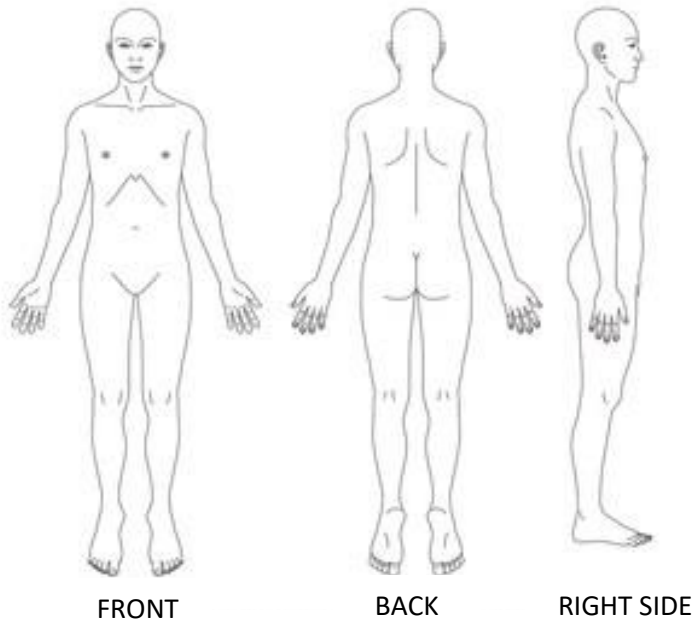
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

H. Below is a list of words that may describe your pain:

Please rate each word on the scale of 0-3 point scale to describe your pain.

	None	Mild	Moderate	Severe
Throbbing	0) _____	1) _____	2) _____	3) _____
Shooting	0) _____	1) _____	2) _____	3) _____
Stabbing	0) _____	1) _____	2) _____	3) _____
Sharp	0) _____	1) _____	2) _____	3) _____
Cramping	0) _____	1) _____	2) _____	3) _____
Gnawing	0) _____	1) _____	2) _____	3) _____
Hot-Burning	0) _____	1) _____	2) _____	3) _____
Aching	0) _____	1) _____	2) _____	3) _____
Heavy	0) _____	1) _____	2) _____	3) _____
Tender	0) _____	1) _____	2) _____	3) _____
Splitting	0) _____	1) _____	2) _____	3) _____
Tiring-	0) _____	1) _____	2) _____	3) _____
Exhausting	0) _____	1) _____	2) _____	3) _____
Sickening	0) _____	1) _____	2) _____	3) _____
Fearful	0) _____	1) _____	2) _____	3) _____
Punishing –	0) _____	1) _____	2) _____	3) _____
Cruel	0) _____	1) _____	2) _____	3) _____

I. Please indicate where you have pain:



J. What makes the pain **WORSE**? Be specific.

K. What makes the pain **BETTER**? Be specific.

III. Effects of Pain

1. Circle the number of how much your pain has interfered with your activities this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

2. Circle the number of how bothered or upset you have been about the pain in the **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

3. Circle the number to indicate how much your pain has interfered with your sleep this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

IV. Current Medications

List **ALL** medicines you are **CURRENTLY** taking for medical and pain problems (including prescribed, over-the-counter, herbs, vitamins): (write on the back of this sheet if necessary)

<u>Name</u>	<u>Pill Strength</u>	<u>Number of times per day</u>	<u>Prescribing Doctor</u>	<u>Date Started</u>

Pharmacy Name and Phone# _____

V. History of Your Pain

A. When did your pain start? _____

B. When did your pain become a problem? _____

C. How many times have you gone to the emergency room for pain in the last year? _____

D. What event or events led to your present pain: Accident Other Injury
 Other Disease Cancer No Obvious Cause Surgery Other: _____

E. What do YOU think is the cause of your pain?

VI. Previous Doctors

Have you ever been evaluated at a pain center? Yes___ No___

If Yes list the doctors name _____

Facility Name and Address _____

List **ALL** doctors you have seen for your pain problem (continue on the back of this page if needed).

<u>Date</u>	<u>Name</u>	<u>Specialty</u>	<u>Address/Phone/Fax</u>

VII. Diagnostic Tests (MRI, CT SCANS, X-RAYS, BLOOD TESTS, ETC.):

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

<u>Date</u>	<u>Tests</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____

VIII. Previous Treatments:

Indicate which of the following treatments you have tried for your problem:

- Antidepressants Acupuncture Psychotherapy Homeopathy Narcotics Chiropractor
 Biofeedback TENS Nerve Blocks Massage Relaxion Training
 Exercise Program Traction Physical Therapy Hypnosis Other (List) _____

IX. Previous Medications

Name of Medicine	Dose	Dates of Use	Helpful?	Reasons for Stopping

X. Past Medical Problems, Surgeries, Hospitalizations, and Injuries:

List any operations, hospitalizations, or injuries you have ever had.

Year	Describe (reason for surgery/hospitalizations or type of injury)	Hospital	Doctor

XI. Allergies (if No Known Allergies check here)

List all allergies to medications and the reaction you had to any medicine (or any other allergies) :

Medicine	Reaction	Medicine	Reaction

XII. Review of Systems

Please check if you currently have had any of the following (please indicate next to the item when the problem occurred).

A. General

- Weight Loss
 Poor Appetite
 Severe Fatigue/Low Energy
 Cancer

B. Hematologic

- Anemia
 Easy Bruising
 Bleeding Disorder

- Taking Blood Thinners
- Blood Transfusion

C. Skin

- Rash
- Nail Changes
- Bumps/Nodules

D. Head and Neck

- Headaches
- Visual Changes
- Mouth Problems
- Neck Pain
- TMJ Problems

E. Cardiac

- Exercise Limitations
- Chest Pain
- Irregular Heartbeat
- Heart Murmur
- High or Low Blood Pressure (circle one)
- Circulation Problems
- Ankle Swelling

F. Pulmonary

- Shortness of Breath
- Cough
- Asthma or Bronchitis
- Lung Disease
- Sleep Apnea
- Snoring

G. Endocrine

- Diabetes
- Thyroid Problems

H. Gastrointestinal

- Abdominal Pain
- Nausea or Vomiting (circle)
- Constipation
- Diarrhea
- History of Ulcers or Heart Burn (circle)

I. Genitourinary

- Frequent or Hesitant Urination
- Pain with Urination
- Blood in Urine
- Incontinence
- Sexual Dysfunction

J. Musculoskeletal

- Arthritis Type: _____
- Osteoporosis
- Muscle Pain
- Muscle Wasting
- Fractures Where on Body: _____

K. Neurologic

- Numbness
- Weakness
- Falling
- Stroke
- Seizures
- Memory Loss
- Loss of Balance

L. Infectious Diseases

- Measles
- Mumps
- Chicken Pox
- Rheumatic Fever
- Hepatitis Type: _____
- HIV / AIDS
- Herpes Location: _____
- Shingles
- Post-herpetic Neuralgia

M. Gynecologic

- Pregnant When: _____
- Post-Menopausal, Last Period: _____

XIII. Medical Problems: Please indicate any other medical problems that are not listed above.

XIV. Habits

- A. Smoking: Yes___ No___ Quit___ Number of Packs/Day___ Number of Years Smoked___
- B. Alcohol Use: None___ Occasional___ Daily___ How Many Drinks Per Week? _____
- C. Recreational Drugs: Current use? Yes___ No___
___ Cocaine ___ Amphetamine ___ Marijuana ___ Heroin ___ Other
- D. Coffee/Tea/Caffeine: Number of Cups/Day _____
- E. Clenching teeth: Yes___ No___ Grinding Teeth: Yes___ No___
- F. Do you wear a night guard over your teeth? Yes___ No___ If you have a night guard, is it? ___ Hard ___ Soft
Is it worn on your ___ Upper ___ Lower

XV. Exercise

- A. Do you exercise? Yes___ No___
- B. If YES then what type of exercise? _____

