NOVA Orofacial Pain, TMD & Dental Sleep Medicine
5222 Rolling Rd.
Burke, Virginia 22015
703-389-0111 Fax: 703-389-7755

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

NOVA Orofacial Pain, TMD & Dental Sleep Medicine
8987 Hersand Dr.
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):

Eyelid 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 joints? 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

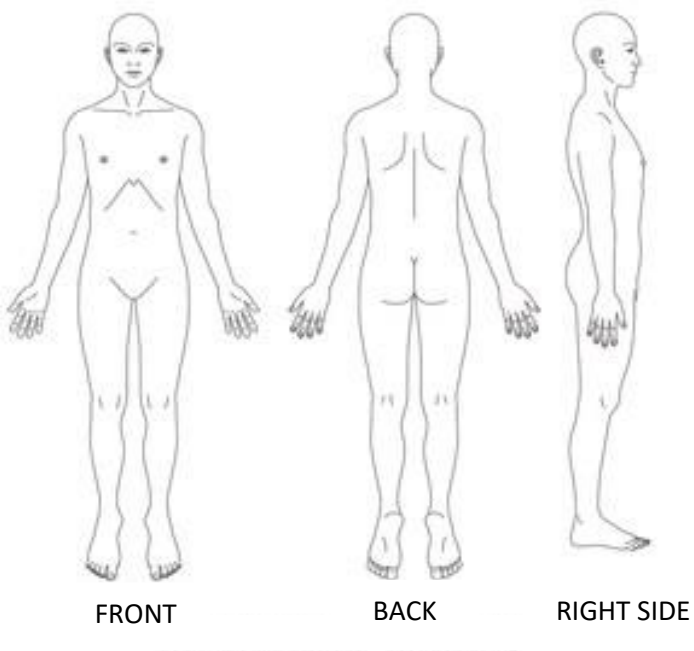
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

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-Exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing – 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)

Name	Pill Strength	Number of times per day	Prescribing Doctor	Date Started

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).

Date	Name	Specialty	Address/Phone/Fax

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

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

Date Tests Results

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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, hopitalizations, 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)
- ☐ Circualtion Problems
- ☐ Ankle Swelling

F. Pulmonary

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

G. Endocrime

- ☐ 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: 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? _____
C. How many days per week do you exercise? _____
D. How long do you exercise each time (on average) _____?

XVI. *Family History*

Member	Deceased or Living	Age	Medical Problems
1. Father	_____	_____	_____
2. Mother	_____	_____	_____
3. Siblings	_____	_____	_____
4. Spouse	_____	_____	_____

Are you adopted? Yes___ No___

XVII. *Social History*

A. Relationship Status:

- ◻ Single
- ◻ Separated
- ◻ Significant Other
- ◻ Divorced
- ◻ Married
- ◻ Widowed

B. Highest Level of Education Completed:

- ◻ GED
- ◻ College
- ◻ High School
- ◻ Graduate
- ◻ Vocational
- ◻ Other _____

C. With whom do you live? Name: _____ Relationship: _____

D. What is your current employment?

- ◻ Employed Full Time
- ◻ Retired
- ◻ Employed Part Time
- ◻ Unemployed Due To Pain
- ◻ Self-employed
- ◻ Unemployed Due To Other Reason
- ◻ Homemaker
- ◻ How Long Have You Been Unemployed or Retired? _____

Are You On Disability? Yes___ No___
Date Disability started: ____
Reason for Disability: _____

E. Number of hours worked per week:_____ Are you happy with your job?____

XI. *Financial Information*

Do you have any legal action pending related to this pain or any other health issue? Yes___ No___ if yes please list:

Attorneys Name_____

Address _____Phone Number_____

XIX. *Psychological History*

1. Describe your mood: _____
_____
_____

2. Do you Have problems with the following:

◻ Concentration	◻ Anxiety	◻ Homicidal Thoughts
◻ Motivation	◻ Depression	◻ Appetite
◻ Sleep	◻ Self-Worth	◻ Suicidal Thoughts

3. Do you have a history of physical or mental abuse? Yes___ No___

4. Are you currently in therapy? Yes___ No___

5. If Yes, Name _____: Degree M. D. _____; Ph. D. _____; MFCC _____
Phone # (____) _____

6. If Yes, how often do you see the person in 5# above:
_____