Smiles for life dental group **Dr Pooja Goel DDS**
Sanjose Sleep Solutions
310N Winchester Blvd, Santa clara ,CA 95050 TEL. 408241-6501 Fax – 408241-6056
1569 Lexann Ave #228 Sanjose, CA 95121 TEL . 408216-8811 Fax-408241-6056

PERSONAL INFORMATION

Name: _____How should we address you? _____

Address: _____, _____, _____
Street City, State Zip

Home Phone: (_____) _____ Business Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Social Security: _____/_____/_____ DOB: _____ Age: _____ Ages of Children: _____

Employer: _____ Occupation: _____

SPOUSE

Spouse's Name: _____ Date of Birth: _____/_____/_____ Age: _____

Spouse's Employer/Occupation: _____ Social Security: _____/_____/_____

PHYSICIAN CONTACT INFORMATION

Family Dentist:_____ _____ Phone: (_____) _____
Address: _____, _____, _____
Street City, State Zip

Family Physician:_____ Phone: (_____) _____

Address: _____, _____, _____
Street City, State Zip

Whom may we thank for referring you to our office? _____
Address: _____, _____, _____
Street City, State Zip

PHYSICIAN AND TREATMENT INFORMATION

Below, please list in chronological order any dentists, physicians, chiropractors, psychologists, psychiatrists, physical therapists, or any other therapists you have consulted. Also, list their specialties and briefly describe their diagnoses and treatments. (Write additional information on a separate sheet of paper, if necessary).

1	DOCTOR	SPECIALTY	ADDRESS and PHONE
			Street: City, State, Zip: Office phone: (_____)
Diagnosis and Treatment(s):			
2	DOCTOR	SPECIALTY	ADDRESS and PHONE
			Street: City, State, Zip: Office phone: (_____)
Diagnosis and Treatment(s):			
3	DOCTOR	SPECIALTY	ADDRESS and PHONE
			Street: City, State, Zip: Office phone: (_____)
Diagnosis and Treatment(s):			

GENERAL HEALTH

Please answer all of the following questions by circling "Yes" or "No". Have you ever had or do you now have…

a	Yes / No	Arthritis? Where?:	i	Yes / No	Artificial joints or implants? When/where placed?
b	Yes / No	Osteoarthritis? Where?	j	Yes / No	A blow to the head? When?
c	Yes / No	Rheumatic arthritis? Where?	k	Yes / No	Whiplash injury? When?
d	Yes / No	Sinus infections? When?	l	Yes / No	Medication allergies? What?
e	Yes / No	High blood pressure? When diagnosed?	m	Yes / No	List all current medications taken:
f	Yes / No	Frequent headaches? Where?	n	Yes / No	Describe physical diseases/problems:
g	Yes / No	Migraine headaches? Where?	o	Yes / No	Have you developed emotional problems due to your disorders that brings you to our office?
h	Yes / No	Mitral valve prolapse? When diagnosed?	p	Yes / No	Describe anything else about yourself that might be related to your condition:

CHIEF COMPLAINTS

a. In your own words, please briefly describe the main problem that brings you to our office:

b. Did your problem begin (circle one that applies): Suddenly Gradually Unknown
c. How long has this problem bothered you? _____Years _____Months _____Days _____ Unknown
d. Which side do your symptoms affect (circle one)? Right / Left / Both / They are Equal

PAIN SYMPTOMS

Do you have PAIN or DISCOMFORT in any of the following areas? Circle all that apply and mark with an "X" on the line:
0 = NO PAIN to 10 = MOST SEVERE PAIN IMAGINABLE

a	TMJ (jaw joint)	Right	0_____5_____10
		Left	0_____5_____10
b	Ear	Right	0_____5_____10
		Left	0_____5_____10
c	Upper teeth or jaw	Right	0_____5_____10
		Left	0_____5_____10
d	Lower teeth or jaw	Right	0_____5_____10
		Left	0_____5_____10
e	Temple	Right	0_____5_____10
		Left	0_____5_____10
f	Eye	Right	0_____5_____10
		Left	0_____5_____10
g	Cheek	Right	0_____5_____10
		Left	0_____5_____10
h	Throat	Right	0_____5_____10
		Left	0_____5_____10
i	Neck	Right	0_____5_____10
		Left	0_____5_____10
j	Shoulder	Right	0_____5_____10
		Left	0_____5_____10
k	Face	Right	0_____5_____10
		Left	0_____5_____10
l	Tongue	Right	0_____5_____10
		Left	0_____5_____10
m	Forehead	Right	0_____5_____10
		Left	0_____5_____10

PAIN SYMPTOMS

n	Circle all pain types that apply:	Sharp	Dull	Aching	Deep	Superficial	Burning	Pulsating	Spreading	Tingling

o	Is the pain CONSTANT or INTERMITTENT? (please circle one)					
p	Does the pain last for (circle):	Seconds?	Minutes?	Hours?	All Day?	Longer?
q	Does the pain start:	Suddenly?	Gradually?	It is constant		
r	Does the pain stop:	Suddenly?	Gradually?	It never stops		
s	What time of the day is the pain most severe?					
t	How often do you experience pain?					
u	What medication, if any, relieves the pain?					
v	Does rest INCREASE or DECREASE the pain (circle one)?					
w	Please describe any method or position of your jaw or head that might reduce or eliminate your pain:					
x	Do any of the following activities cause discomfort or pain when you (Please circle all that apply):					

Speak	Sing	Yawn	Chew	Swallow	Shout	Move head	Wash face	Brush teeth	Apply makeup	Sit at computer

JAW JOINT SYMPTOMS

a	Yes / No	Can you open your mouth (circle one): Normally? Partially? Not at all?				
b	Yes / No	Does your mouth ever lock open or closed?				
c	Yes / No	Do your jaws ever momentarily "go out" or get stuck?				
d	Yes / No	Do you experience any of these sounds in the jaw joint?				
e	Yes / No	Do you experience any of these sounds in the jaw joint?	Clicking Right / Left	Popping Right / Left	Snapping Right / Left	Grating Right / Left
f	Yes / No	If you experience any of the above sounds, is it <u>frequently</u> or <u>occasionally?</u>				
g	Yes / No	Have you noticed any change in your chewing ability?				
h	Yes / No	Have you noticed any changes in your bite?				

MISCELLANEOUS & ASSOCIATED COMPLAINTS

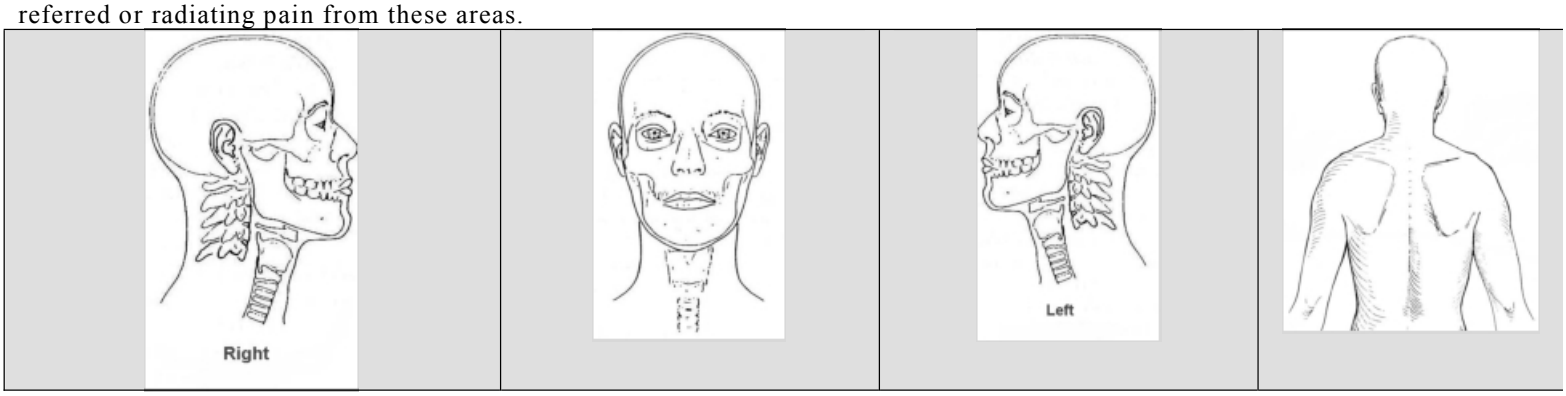
Please circle the appropriate answers that apply to you

a	Yes / No	Have you had a change in your hearing?
b	Yes / No	Do you experience tinnitus (ringing) in your ears?
c	Yes / No	Have you ever experienced dizziness, nausea or fainting?
d	Yes / No	Have you experienced fullness, blockage or pressure in your ears?
e	Yes / No	Your jaws or teeth sore when you awaken?
f	Yes / No	Are your facial muscles tired or sore when you awaken?
g	Yes / No	Do you clench or grind your teeth when you sleep?
h	Yes / No	Do you clench or grind your teeth during moments of frustration or concentration?
i	Yes / No	Is there anyone else in your family who has a similar problem?
j	Yes / No	Have you been treated with orthodontic therapy?
k	Yes / No	Has your dentist ever adjusted your occlusion (bite)?
l	Please briefly describe any changes in the location or character of your symptoms since this problem began:	
m	Referring back to former doctors, did any of their treatments make you feel better? If so, which treatments?	
n	Did any of these former treatments make you feel worse? If so, which ones?	
o	Do any of the symptoms discussed so far in this history begin after any of the following (circle all that apply):	

Blow to jaw	Whiplash Injury	Dental appointment	General Anesthesia	Severe upset (emotional)	Biting on an object	Excessively large bite or yawn

PAIN PATTERNS

Please mark on the drawings below with a colored "X" on the area(s) which you feel pain is occurring. Draw patterns, if any, of referred or radiating pain from these areas.



TRAUMA

a	Yes / No	Have you ever been injured in a motor vehicle accident? If so, when?
If a motor vehicle accident or a blow to the face or head produced the problems which bring you to our office, please give complete details including when, where, how it occurred, and any medical treatment required, where and by whom (Use separate sheet of paper if necessary):		
b	Yes / No	Do you feel the problem that brought you to our office is a direct result of this accident?
c	Yes / No	Were you experiencing any of the following problems BEFORE your accident or injury (Circle all that apply): Headaches – Earaches – Facial pain – TMJ problems – Neck pain – Back pain – TMJ Noise
d	Yes / No	Before your accident or injury, were you ever treated by any type of doctor or therapist for the following: Headaches – Earaches – Facial pain – TMJ problems – Neck pain – Back pain – TMJ Noise
e	Yes / No	Have you ever had an injury to the jaw, face, head or neck other than the one described above? If yes, describe:

PATIENT DISCLOSURE CONFIRMATION

I, _____, on this date, have personally completed this entire history form or it was prepared under my direct supervision. Further, I state that the answers are accurate to the best of my recollection. I also give permission to Sanjose sleep solutions to use this information, pictures, or x-rays anonymously for research purposes (optional). I am here for treatment and I am not representing any third party or government agency.

Patient Signature: _____ Date: _____

Representative: _____ Date: _____
(Sign if the patient is a minor child or patient requires a legal representative.)

INSURANCE INFORMATION

YES	NO	I have contacted my dental and/or medical carrier regarding evaluation and treatment by The TMJ & Facial Pain Center.
YES	NO	I understand that The Sanjose sleep solutions requires payment the day service is provided. The Sanjose Sleep solutions is not a participating provider with most insurance plans and I am required to notify my carrier for prior approval. I have notified The TMJ & Facial Pain Center of my insurance status.

PRIMARY Subscriber (Insured Person) Information

Subscriber Name:	Relationship to patient: Self / Spouse / Parent
Address:	
City, State, Zip:	Date of Birth: _____/_____/_____
Phone:	Social Security #: _____ - _____ -_____

MEDICAL Insurance Plan

MEDICAL Insurance:	Employer:
Address:	Effective Date:
City, State Zip:	ID #:
Phone:	Group #:

DENTAL Insurance:	Employer:
Address:	Effective Date:
City, State Zip:	ID #:
Phone:	Group #:

SECONDARY Subscriber Information

Subscriber Name:	Relationship to patient: Self / Spouse / Parent
Address:	ID #:
City, State, Zip:	Date of Birth: _____/_____/_____
Phone:	Social Security #: _____ - _____ - _____

MEDICAL Insurance Plan

MEDICAL Insurance:	Employer:
Address:	Effective Date:
City, State Zip:	ID #:
Phone:	Group #:

DENTAL Insurance Plan

DENTAL Insurance:	Employer:
Address:	Effective Date:
City, State Zip:	ID #:
Phone:	Group #:

SIGNATURE

I authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. Where applicable, I authorize payment of medical benefits to Sanjose sleep solutions Center for services described and for services for which he accepts assignment of my medical benefits.

Signature of Insured: _____ Date: _____

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Pain management Agreement

The purpose of this Agreement is to prevent misunderstanding about certain medicines you may be taking for pain management. This is to help both you and Sanjose sleep Solutions to comply with the laws regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that Sanjose sleep solutions undertakes to treat me based on this Agreement.

I understand that if I break this Agreement,Sanjose sleep solutions will stop prescribing any controlled substances and may stop all treatment. In this case, Sanjose sleep solutons will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program and referral to another doctor or facility may be recommended.

I will communicate fully with Sanjose sleep solutions Center about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell, or trade my medication with anyone. I will submit to random drug testing if Sanjose sleep solutions feels such testing is warranted.

I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled substances, or anti-anxiety medicines from any other doctor while in treatment with Sanjose sleep solutions.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends and calling Sanjose sleep solutions after hours and on weekends or holidays will result in cessation of all prescriptions and termination of your relationship with Sanjose sleep solutions.

I authorize Sanjose sleep solutions and my pharmacy to cooperate fully with any city, state and/or federal law enforcement agencies in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize Sanjose sleep solutions to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I will not go to emergency rooms for pain management of my chronic condition for which Sanjose sleep solutions is treating me. This agreement does not refrain me from going to an emergency room for new acute pain of any nature. I shall report to Sanjose sleep solutions within a week of such an emergency room visit.

I agree that I will submit to a blood or urine test if requested by Sanjose slepp solutions to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of any medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

Pharmacy Information

I agree to use (name of pharmacy): _____,
Located at: _____,
Pharmacy Phone number: (_____)_____, for filling prescriptions for all of my pain medicine.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient's Signature: _____ Date: _____

Notice of Privacy Policies

Sanjose sleep solutions

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Sanjose sleep solutions.

Sanjose sleep solutions Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective 04/01/2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized

federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected health information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you an initial fee of fifteen dollars, one dollar a page for the first ten pages, fifty cents per page for pages eleven through fifty and twenty cents per page for pages fifty-one and higher. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Dr Pooja goel
Telephone: (408)241-6501,(408)216-6501
Fax: (408)241-6056
E-Mail:
Address: 310N Winchester Blvd , 1569 Lexann Ave #228 Sanjose CA 95121

City, State, Zip: Santa clara CA 95050

Consent for Use and Disclosure of Personal Health Information (HIPAA)

This form authorizes us to use and disclose your Protected Health Information (PHI) for the purpose of healthcare operations, treatment and payment activities. Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI. For questions concerning our Notice of Privacy Policies, please contact:

Practice Name: Sanjose sleep solutions
Contact: 1569 Lexann Ave #228 Sanjose, CA 95121
Telephone:(408)216-8811

Patient Information

Patient Name	Address	City, State, Zip	SSN	Birthdate

Patient Consent / Acknowledgement of Receipt of Privacy Policies

I, _____, have received and read your Notice of Privacy Policies and I consent to your use of my PHI (private health information) for the purpose of healthcare operations, treatment and payment.

_____ Patient (or representative) Signature	_____ Printed Name	_____ Relationship to patient	_____ Date

_ _

COMPLETE BELOW ONLY IF REVOKING OR REFUSING YOUR CONSENT

You have the right to revoke your consent at any time or to refuse to sign the consent. We reserve the right to deny or discontinue treatment for refusal to sign or revocation of signature.

Patient Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

_____ Patient (or representative) Signature	_____ Printed Name	_____ Relationship to patient	_____ Date

Refusal to Sign – Office Use Only

An Acknowledgement of Receipt of Notice of Privacy Policies form was delivered. The form was not signed due to:

	Communication barriers which prevent acknowledgement
	Emergency which prevents acknowledgement
	Refusal to sign
	Other