



SOUTHWEST PAIN MANAGEMENT ASSOCIATES

Dear Patient:

Thank you for selecting our office. We welcome the opportunity to serve you! Your initial appointment is scheduled on _____ at _____ at the _____ location.

FOR YOUR INITIAL APPOINTMENT

Please completely and accurately fill out all of the enclosed forms. Have available the names, addresses and phone numbers of any health care provider we may need to contact. All of the information is necessary for our records and kept confidential. Try not to take any pain medication within eight hours of your initial appointment so as not to mask any symptoms. Please bring a complete list of all medications and doses you are presently taking and, if available, bring any x-rays or office notes that you can obtain- If you have any type of splint or brace, please bring that as well. We also will require any and all insurance, payer, or attorney information. Include company name, address, phone number, and policy or claim numbers.

FOR ALL APPOINTMENTS

Please arrive on time and understand if we cannot see you immediately. Due to the nature of the medical specialties we serve, sometimes we need more time than planned in order to serve our patient's needs. If you must cancel or reschedule an appointment, please notify us at least 24 hours in advance. Please refrain from wearing perfume or other scented products.

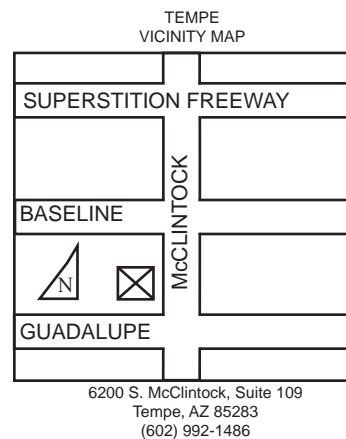
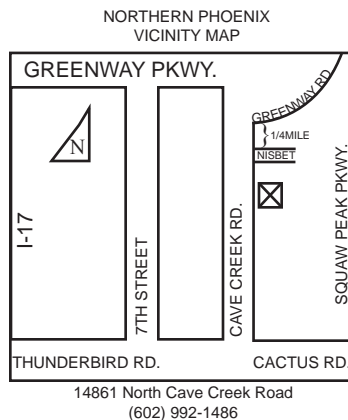
FINANCIAL RESPONSIBILITY

As quoted, your financial responsibility for your initial examination is \$ _____ due the day of the appointment. We accept cash, check, Visa, MasterCard, Discover, and American Express. Future treatment costs will be discussed at your initial visit. We do ask for payment in full for services rendered unless other arrangements have been made.

If you have any questions, please do not hesitate to contact our office. We look forward to meeting you!

Sincerely,

Southwest Pain Management Associates





SOUTHWEST PAIN MANAGEMENT ASSOCIATES

Joseph R. Cohen, D.D.S.

Diplomate, American Board Orofacial Pain

Consent Form for Care

I, _____ agree to be evaluated and treated at Southwest Pain Management.

The evaluation will consist of a personal interview by the Physician or Dentist, review of records and a hands-on physical examination. Laboratory and radiographic testing may be ordered. On occasion, a thorough exam will increase your pain for a short period of time.

As part of your care, you may receive injections of one kind or another. Usually, these are trigger point injections into the motor point of various muscles that are causing you pain.

Side effects can include: allergic reactions, localized pain at the injection site or pain along the referral pattern of the nerve or muscle injected. On rare occasions more serious adverse events have been known to occur: fever, infection, muscle and bone, atrophy, rash, anaphylaxis, pneumothorax, breathing difficulty, sudden changes in blood pressure, convulsions and death.

If a procedure is going to be done, a further discussion will ensue, but you are encouraged to ask questions. We wish to empower you to seek a higher level of health by getting involved. Help us to understand you.

A thorough dental explanation is not included. Any obvious dental lesions will be brought to your attention. For proper dental care and treatment please see your general dentist on a regular basis.

Thank You: The Providers at Southwest Pain Management

Patient Signature _____

Date _____

SOUTHWEST PAIN MANAGEMENT ASSOCIATES



AUTHORIZATION TO RELEASE RECORDS

Complete this form with the names, addresses and phone numbers of all health care providers which you have seen for your condition and initial the entries of the providers you would like to receive a report.

I hereby authorize Southwest Pain Management Associates to release records or discuss my care with any of the following health care providers or lien holders or their agents:

_____	Initial	Initial	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			_____
_____			_____
_____	Initial	Initial	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			_____
_____			_____
_____	Initial	Initial	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			_____
_____			_____

This office is concerned with the diagnosis and treatment of pain and discomfort related to Temporomandibular Joint Dysfunction (TMJ) and/or occlusal disorders. Craniofacial (head and face) and cervical (neck) symptoms can originate from a variety of causes. Frequently pain is a many-faceted problem requiring a multidisciplinary approach. Patients may subsequently be referred to specialists.

Because of the potential complexity of head and neck pain, and the highly variable degree of structural damage to the joint, the prescribed treatment may not eliminate the symptoms. It is imperative the patient understands this.

Following a period of comfort and stability, a decision for final treatment can be made. Treatment may rarely cause irreversible bite changes that may require dental treatment to correct. Follow up treatment may include orthodontics, crown and bridge, permanent removable splints, surgery, night splints only, and new partial or full dentures when indicated. At the appropriate time, a bite analysis will be performed, and the most conservative recommendation will be made. Regardless of the finalized treatment choice, subsequent modification to the chewing surfaces of the teeth may be necessary to optimize the relationship between the teeth, jaws, and muscles.

If proper cleaning techniques are not used, you may be susceptible to decay on the tooth surfaces covered by the splint.

I acknowledge, having read and understood the foregoing, and consent to treatment for TMJ dysfunction and/or occlusal disorders.

Date

Signature of Patient (or Guardian)

SOUTHWEST PAIN MANAGEMENT ASSOCIATES



PATIENT INFORMATION

Name: _____ Date: _____

Social Security #: _____ Home Phone: _____

Address: _____

Birthdate: _____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Guardian's Name (If minor) _____ Relationship to patient: _____

Driver License #: _____ Occupation: _____

Employer: _____ Work Phone: _____

Employers Address: _____

Name of Spouse: _____

Spouses Employer _____

In case of emergency, please list two family members/significant others we may contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

Date of last physical examination: _____

Referred by: _____ Phone: _____

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE COMPANY BENEFITS BE PAID ON MY BEHALF TO THIS OFFICE FOR ANY SERVICES PROVIDED BY THIS PHYSICIAN. I UNDERSTAND MY SIGNATURE REQUESTS PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION Necessary TO PAY THE CLAIM. IF ITEM 9 OF HCFA-1500 IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

IN THE EVENT THAT PAYMENT IS NOT MADE ON THIS ACCOUNT AND IT IS PLACED WITH A LICENSED COLLECTION AGENCY, I AGREE TO PAY THE FEES OF THE COLLECTION AGENCY EQUAL TO A MAXIMUM OF 50% OF THE OUTSTANDING BALANCE AT THE TIME THE ACCOUNT IS PLACED WITH THE AGENCY, INTEREST OF 10% PER YEAR WILL BE ACCRUED ON THE PRINCIPAL BALANCE. I PROMISE TO PAY LEGAL INTEREST ON THE INDEBTEDNESS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION.

Signature: _____ Date: _____

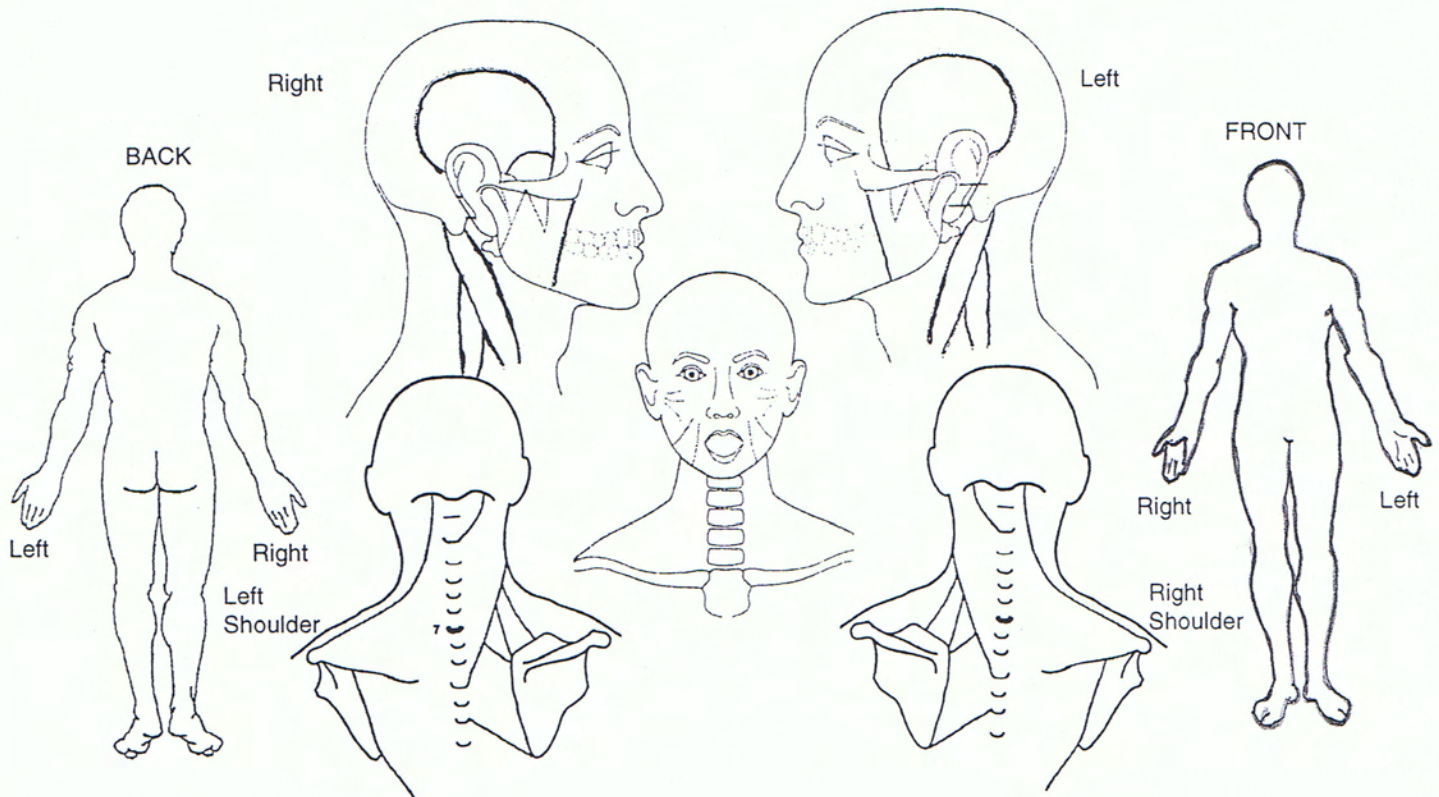
SOUTHWEST PAIN MANAGEMENT ASSOCIATES



PAIN STATUS INVENTORIES

PAIN DRAWING

Circle the areas on your body in which you have any discomfort/pain. Include all affected areas.



Pain in arm(s) compared with neck: worse same less
 Pain in leg(s) compared with back: worse same less

Modified McGill Pain Questionnaire: (The idea is just to have you pick words that describe your pain. Try and be selective in marking those that apply:)

THROBBING:	None	Mild	Moderate	Severe
SHOOTING:	None	Mild	Moderate	Severe
STABBING:	None	Mild	Moderate	Severe
SHARP:	None	Mild	Moderate	Severe
CRAMPING:	None	Mild	Moderate	Severe
GNAWING:	None	Mild	Moderate	Severe
BURNING:	None	Mild	Moderate	Severe
ACHES:	None	Mild	Moderate	Severe
HEAVY:	None	Mild	Moderate	Severe
TENDER:	None	Mild	Moderate	Severe
SPLITTING:	None	Mild	Moderate	Severe
EXHAUSTING:	None	Mild	Moderate	Severe
SICKENING:	None	Mild	Moderate	Severe
FEARFUL:	None	Mild	Moderate	Severe
PUNISHING:	None	Mild	Moderate	Severe

MEDICAL HEALTH HISTORY

Are you currently taking any of the following medications?

Name	Dose/day	Name	Dose/day
Antibiotics _____	_____	Tylenol _____	_____
Anti-inflammatory _____	_____	Insulin _____	_____
Anti-seizure _____	_____	Orinase, etc. _____	_____
Sulfa Drugs _____	_____	Digitalis _____	_____
Anticoagulants _____	_____	Stomach Meds _____	_____
HBP* Drugs _____	_____	Oral Contraceptives _____	_____
Cortisone (Steroids) _____	_____	Pain Meds _____	_____
Sleeping Pills _____	_____	Antidepressants _____	_____
(Barbiturates) _____	_____	Vitamins or _____	_____
Antihistamines _____	_____	Supplements _____	_____
Aspirin _____	_____	Other _____	_____

*High Blood Pressure

	Now	Past	No		Now	Past	No
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Poor digestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stomach gas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Swallowing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reactions to Lead/mercury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Laxative use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irregular menstrual problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menstrual Cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopausal problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hemorrhoids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormone Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduced sex desire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gall Bladder problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sleep apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prostate problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fatigue easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed after work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Low energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronically tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moody often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional upsets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervous breakdown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis, rheumatoid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lose temper easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle spasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Perfectionist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Osteo-arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychological care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hands tremors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hands get cold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Feet get cold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental retardation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Leg cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Swollen ankles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Swollen hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Polio	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> O <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Numbness of fingers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jaundice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Parkinson's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Multiple sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gum chewing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grinding/clenching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fibromyalgia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Atrial fibrillations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any blood disease such as anemia? Yes No

Have you had surgery, x-ray, or drug treatment for a growth or other condition to your head, neck or back? Yes No

Do you have any disease, condition or problem not listed here that you think we should know about? Yes No

Please explain: _____

MEDICAL HEALTH HISTORY (continued)

Personal History:

Please list your most serious illnesses and injuries:

Please list your operation history:

Please list any known allergies (Other than medications):

Please describe any regular exercise you do: _____

Nutritional History:

- | | | |
|--------------------|---------------------------|--------------------------|
| Do you usually eat | <input type="radio"/> Yes | <input type="radio"/> No |
| Breakfast | <input type="radio"/> Yes | <input type="radio"/> No |
| Lunch | <input type="radio"/> Yes | <input type="radio"/> No |
| Dinner | <input type="radio"/> Yes | <input type="radio"/> No |
| Between Meals | <input type="radio"/> Yes | <input type="radio"/> No |
| Before Bed | <input type="radio"/> Yes | <input type="radio"/> No |

How often do you have:

- | | 3x/day | daily | 3x/week | 3x/month | never |
|------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Milk | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Dairy products | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Coffee | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| De-Caf coffee | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Refined sugar | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| White bread | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Artificial sugar | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Soft drinks | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Alcohol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Beer | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Wine | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Salt | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chinese food | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Family History:

Have your mother or father, or their parents had any of the following disorders?

- | | | |
|------------------------|---------------------------|--------------------------|
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Arthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Obesity | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart trouble | <input type="radio"/> Yes | <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes | <input type="radio"/> No |
| Dental problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Mental health problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Kidney disorders | <input type="radio"/> Yes | <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| Allergies | <input type="radio"/> Yes | <input type="radio"/> No |
| Headaches | <input type="radio"/> Yes | <input type="radio"/> No |
| Alcoholism | <input type="radio"/> Yes | <input type="radio"/> No |
| High blood pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Arteriosclerosis | <input type="radio"/> Yes | <input type="radio"/> No |

Are you allergic or have you reacted to:

- | | | |
|---------------------------------|-----|----|
| Local Anesthetics | Yes | No |
| Penicillin or other Antibiotics | Yes | No |
| Sulfa Drugs | Yes | No |
| Barbiturates | Yes | No |
| Aspirin | Yes | No |
| Lodine | Yes | No |
| Codeine or other Narcotics | Yes | No |
| Other _____ | | |

Have you had abnormal bleeding? Yes No

Do you bruise easily? Yes No

Have you ever required a blood transfusion Yes No

If so, please explain the circumstances _____

Women:

- | | | |
|-------------------|---------------------------|--------------------------|
| Are you pregnant? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you nursing? | <input type="radio"/> Yes | <input type="radio"/> No |

I certify that I have read and understand the above. I acknowledge that my questions if any about inquiries set forth above have been answered to my satisfaction. I will not hold my physician/dentist, or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of Patient/Date _____

Signature of Doctor/Date _____

Pain Evaluation

Please circle all that apply.

Chief Complaint (s): Jaw Pain Jaw Popping Lips Tongue Cheek Toothache Temple Neck Headaches Migraines
Facial Pain Facial Swelling Bite Off Mouth Earache Limited Opening Tired Jaw Muscles Sore Jaw Muscles Jaw
Locking Difficulty Opening
Other _____

Starting When? Less than 1 Month 1-3 Months 4-6 Months 6 Months - 1 Year Over 1 Year
Or Specify Exactly When _____

After any of the following? Injury to Back Broken Jaw Broken Nose Head Surgery Neck Surgery Dental Filling
Orthodontics Yawning Biting Head Injury Cervical Traction Dental Treatment Wide Opening Jaw Trauma
Emotional Upset Neck Injury Whiplash
Auto Accident Work Accident Not Sure Nothing Other _____

When does it bother you? Morning Midday Evening Wakes you from sleep Intermittent Decreases during day
Increases during day Not Sure Other _____

How long does it last? _____

Describe the quality: Sharp Shooting Burning Numbness Ache Pulsing Throbbing Stabbing Electric Shock
Other _____

Intensity Level (1=lowest 10=highest) 1 2 3 4 5 6 7 8 9 10

What makes you feel worse? Yawning Chewing Swallowing Speaking Singing Shouting Brushing Teeth Turning
Neck Turning Head Turning Trunk Moving Arms Moving Shoulders Stress Moving Jaw Nothing Don't Know
Drinking Eating Touching Area Not Sure
Other _____

What makes you feel better? Rest Sleep Heat Ice Massage Medication Nothing
Other _____

Please describe if there is any method of positioning your jaw that will relieve your pain:

Have you had any serious trouble associated with any previous dental treatment?

Other Symptoms: None Eye Tearing Nasal Stuffiness Red Eyes Nausea Light Sensitivity Noise Sensitivity Swollen
Eyes Droopy Eyes Ear Ringing Popping Noises Itchy Ears Hearing Loss Grating Noise Muscle Soreness Muscle
Spasms Salivary Changes Eye Pressure Facial Swelling Cheek Biting Lip Biting Temperature Sensitivity Sensitive
Teeth Tense Muscles Warm Muscles Tired Muscles Other _____

Past Treatment: None Physical Therapy Chiropractic Biofeedback Counseling Extraction Root Canal
Crown/Bridge Dental Treatment Prosthetics Occlusal Adjustment Medication
Nightguard Surgery Massage Orthodontics Other _____

Please indicate anything else about yourself, which you suspect may be related to your visit

SOUTHWEST PAIN MANAGEMENT ASSOCIATES



PSYCHOLOGICAL HISTORY

Pain Disability Index: How much does your pain OVERALL interfere with each of the following activities? Give me an estimate from ZERO to 100%. Zero means that your pain DOES NOT interfere with this activity. 100% means that you absolutely cannot do this activity 100% of the time. If you put down 30% or 40%, it means that 30% of the time pain interferes with this activity.

- | | | | |
|---------------------------------|---------|--------------------|---------|
| 1. Family/Home Responsibilities | _____ % | 6. Sexual Activity | _____ % |
| 2. Recreation | _____ % | 7. Driving | _____ % |
| 3. Social Activity | _____ % | 8. Getting Dressed | _____ % |
| 4. Occupation | _____ % | 9. Sleeping | _____ % |
| 5. Showering | _____ % | 10. Eating | _____ % |

Please circle any of the following problems which pertain to you:

- | | | | | |
|-------------------|---------------|---------------|--------------|----------------------|
| Nervousness | Depression | Fears | Shyness | Sexual Problems |
| Suicidal Thoughts | Separation | Divorce | Finances | Drug Use |
| Alcohol Use | Friends | Anger | Self-control | Unhappiness |
| Sleep | Stress | Work | Relaxation | Headaches |
| Tiredness | Legal Matters | Memory | Ambition | Energy |
| Insomnia | Loneliness | Temper | Appetite | Making Decisions |
| Concentration | Education | Children | Marriage | Inferiority Feelings |
| Career Choices | My Thoughts | Nightmares | Parenting | Health Problems |
| Stomach Trouble | Bowel Trouble | Others: _____ | | |

List the members of your family and all others in your home:

Name(s)	Age/Birth Date	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have ever received psychiatric or psychological help or counseling of any kind before? _____

If you have, please explain: _____

SOUTHWEST PAIN MANAGEMENT ASSOCIATES



ACCIDENT HISTORY (ONLY COMPLETE IF THERE IS LITIGATION)

Location of accident (street, city, state): _____

Your Name: _____

Date of Accident: _____

Were you the driver? _____

If possible, draw location of vehicles at time of impact

If passenger, circle where you were seated Front Rear Right Center Left

Approximate speed of your vehicle: _____

Approximate speed of other vehicle: _____

Were you wearing a seatbelt at the time of impact? Yes No

Your vehicle struck was struck by another vehicle.

Was the vehicle you were in at a standstill moving rear-ended?

Was a police report filed? Yes No Date _____

Do you have a copy of police report: _____

Pictures available: _____

Your vehicle sustained damage to: Left Right Front Rear

Amount of damage to your car: \$ _____

Please describe the physical damage done to your car: _____

Other vehicle sustained damage to: Left Right Front Rear

Were any of the drivers given a citation? Yes No Who? _____

Did your face or head strike anything? Yes No What? _____

Describe any trauma (fractures, cuts or bruises): _____

Were there any immediate symptoms (pain, etc.)? Yes No Please describe _____

Did any jaw locking or jaw joint noises develop since the accident? Yes No When? _____

Please describe the symptoms you are experiencing now and when they developed: _____

Did any of the present symptoms exist to any degree before the accident? Yes No Which? _____

Did you receive medical care? Yes No

Name of hospital: _____ Were x-rays taken? _____

What was the diagnosis? _____

What treatment, if any, was rendered? _____

Did it help? Yes No Explain: _____

Was there any other health provider? Yes No

If yes, please list providers: _____

Were you absent from work because of this injury? Yes No

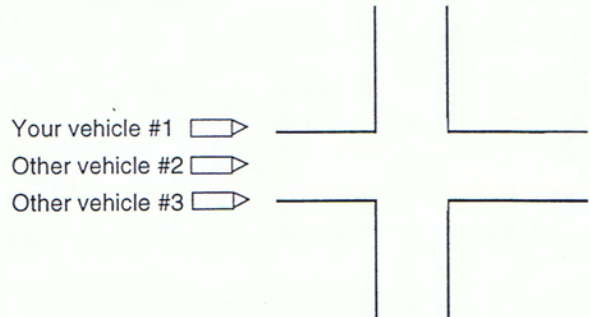
If yes, how long? _____

Is there litigation? _____

If yes, what is the name of your attorney? _____

Attorney's address: _____

Phone# _____



SOUTHWEST PAIN MANAGEMENT ASSOCIATES



INSURANCE/ATTORNEY INFORMATION

Primary Medical Insurance:

Insurance Carrier: _____
Policy Number: _____ Group Number _____
Name of Insured: _____ Employer: _____
Social Security Number: _____
Address of Insurance: _____
Phone Number of Insurance: _____
Secondary Medical Insurance: _____
Insurance Carrier: _____
Policy Number: _____ Group Number: _____
Name of Insured: _____ Employer: _____
Social Security Number: _____
Address of Insurance: _____
Phone Number of Insurance: _____

Dental Insurance:

Insurance Carrier: _____
Policy Number: _____ Group Number: _____
Name of Insured: _____ Employer: _____
Social Security Number: _____
Address of Insurance: _____
Phone Number of Insurance: _____

Automobile Insurance (If applicable):

Insurance Carrier: _____
Policy Number: _____ Group Number: _____
Name of Insured: _____ Social Security Number: _____
Claim Number: _____
Address of Insurance: _____
Phone Number of Insurance: _____

ATTORNEY INFORMATION (if applicable):

Attorney Name: _____
Firm: _____
Street Address: _____
City _____ State/Zip _____
Phone# _____ Fax _____

Workman's Compensation Information, please see next page.

Southwest Pain Management Associates
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign .
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Southwest Pain Management Associates

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information, We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you,

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice 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 health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$30.00 for a copy of your records and health information, \$15.00 to duplicate x-rays and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Southwest Pain Management Associates

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—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 put 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: Ivy Segal
Telephone: (602)992-1486 ext. 317 Fax: (602) 992-6604

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,

SIGNATURE

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 heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written 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 Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Ivy Segal
(602) 992-1486 ext. 317
14861 N. Cave Creek Road
Phoenix, Arizona 85032



SOUTHWEST PAIN MANAGEMENT ASSOCIATES

Joseph R. Cohen, D.D.S.

Diplomate, American Board Orofacial Pain

JOSPEH R. COHEN, DDS

Financial Policy

If we are contracted with your insurance company, co-pays, and/or coinsurance will be due at each visit to our office. If you have a deductible that is not met for the year you will be responsible for payment on the day of your visit as well.

Payment in full is expected at each visit if we are not contracted with your insurance company or if you are receiving services that are not covered by your insurance company unless other arrangements have been made. Your insurance company will be billed as a courtesy, and any payment received will be credited to your account. If you would like a refund you must notify us, otherwise the credit will be held on account for future appointments.

Payment arrangements may be paid by cash, check, credit card or Care Credit.

Patient Signature _____

Date _____



SOUTHWEST PAIN MANAGEMENT ASSOCIATES

Joseph R. Cohen, D.D.S.

Diplomate, American Board Orofacial Pain

Permission to Give/Discuss Your Personal Health Information

Due to the current laws protecting your personal health information, we are not allowed to share any information pertaining to your diagnosis or treatment without your signed consent

Please let us know the following:

I _____ by signing below state that South
(Print Name)

West Pain Management Associates has my signed consent to speak with, or leave messages with, the following people regarding my protected medical information:

Name: _____

Relationship: (Spouse/Partner/Child/Friend/Other)

Phone # _____

Name: _____

Relationship: (Spouse/Partner/Child/Friend/Other)

Phone # _____

Name: _____

Relationship: (Spouse/Partner/Child/Friend/Other)

Phone # _____

Signed: _____ Date _____