PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

National Integrated Health Associates
5225 Wisconsin Ave., NW, Suite 402
Washington, DC 20015

FOR YOU: START HERE

1

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
E-MAIL ADDRESS			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

FOR YOUR CHILD: START HERE

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 INSURANCE

PRIMARY CARRIER
INSURANCE COMPANY
GROUP NO.
EMPLOYEE
DATE OF BIRTH
DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO.
EMPLOYEE SOCIAL SECURITY NO.

SECONDARY CARRIER
INSURANCE COMPANY
GROUP NO.
EMPLOYEE
DATE OF BIRTH
DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO.
EMPLOYEE SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

DID A MEMBER OF YOUR FAMILY OR A FRIEND (WHO IS A NIHA PATIENT) REFER YOU TO THIS OFFICE? NAME: RELATIONSHIP:
IF NOT, HOW DID YOU HEAR ABOUT NIHA?
YOUR FORMER ADDRESS: CITY STATE ZIP
PERSON TO CONTACT FOR EMERGENCY: NAME: PHONE NUMBER: ADDRESS: CITY STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU: NAME: PHONE NUMBER: ADDRESS: CITY STATE ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
E-MAIL ADDRESS		

YOU	
NAME	
OCCUPATI0N	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NO.	EXT.

YOUR SPOUSE	
NAME	
OCCUPATI0N	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NO.	EXT.

AUTHORIZATION & ACKNOWLEDGEMENTS —YEARLY UPDATE

National Integrated Health Associates (NIHA)
5225 Wisconsin Ave. ◆ Suite 402 ◆ Washington DC 20015
Tel: 202-237-7000◆www.NIHAdc.com◆Fax: 202-237-0017

Notice as to Nature of Services: Care I receive at NIHA may be non-conventional and considered integrative, functional, complementary or alternative or holistic medicine or biological dentistry. Many of these services may be supported by a substantial body of clinical literature and taught in continuing medical education but that evidence not considered sufficiently rigorous by mainstream medical institutions to support practice. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed. Laboratory evaluations may include venipuncture, analysis of stool, urine and saliva; some of these tests may be considered nonstandard and interpreted according to functional approaches to medicine.

Notice That Services are Not Primary Care: I understand that the physicians or practitioners I see at NIHA do not act as my primary care physician, except that Dawn Cannon, M.D., Ching Voss, M.D., Denia Tapscott, M.D., and Cathlene Heideman, N.P may provide certain primary care services as defined by mutual written agreement. Even though physicians and practitioners may address a wide range of health issues, they do not become responsible for my health generally simply because he/she may conduct a searching and broad investigation to my chief complaint(s). NIHA practitioners' practice is focused on a complementary, integrative approach to care. It may be in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. NIHA is exclusively office-based and none of its physicians are affiliated with a hospital. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

It is my responsibility to inform NIHA who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I should keep my physician and any practitioners I see informed on an ongoing basis. It is very important to let my primary care physician know about any treatments performed at NIHA in order to properly and safely coordinate my care. I have listed my primary care physicians and specialist on my medical history form and will keep this form updated as needed.

Medical/Dental Records Release Authorization: I have signed a HIPAA authorization allowing NIHA to release my medical/dental information to any physician or health practitioner involved in my care and to any payer of my care including my insurance company, or managed care program upon their specific request. I will authorize any physician or health care provider I have seen to release my medical/dental records to NIHA.

Financial/Insurance Responsibility for All NIHA Services: Payment is required at each visit; NIHA does not accept assignment for medical services. Patients are responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items and any payments for services my insurance carrier determines, now or at a later date, to be unreasonable or not medically or dentally necessary. My insurance carrier or other third-party responsible for coverage of my medical/dental expenses may deny coverage because of differences between integrative and conventional medicine, but I choose to receive and will pay for such care and am responsible for payment of fees for laboratory or other clinical services ordered by my treatment practitioner(s). NIHA will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I am responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for NIHA to take action to secure payment of an outstanding balance owed.

Notice to Medicare Patients: The practitioners at NIHA have opted-out of the Medicare program. Medicare will not cover any services or procedures performed at NIHA. NIHA will not submit claims and I will not be able to submit any claims to Medicare. If I have a secondary insurance carrier that carrier may or may not choose to reimburse claims that would have been covered had I seen a physician who accepts payment for Medicare. I will sign a Medicare Private Contract Agreement agreeing not to submit claims to Medicare, that NIHA will charge the rates it determines without being limited by Medicare fees. I am financially responsible for any services received. Medicare will not be reviewing any claims, and an opinion by Medicare generally that a service is not medically necessary does not change my responsibility to pay for services.

Notice about Tricare Insurance: Tricare patients must alert NIHA staff that they have Tricare coverage. NIHA is a non-participating Tricare provider, and Tricare patients are responsible for payment of NIHA's full fee schedule at time of service and will receive reimbursement directly from the Tricare carrier for any covered amounts payable under Tricare's fee schedule. In order for NIHA to bill its service rates, Tricare patients must review and sign a Request for Non-Covered Services that will give advance notice of anticipated fees. This form provides an informed waiver of the maximum fees for covered services Tricare otherwise imposes, which limits charges by non-participating providers to 115% of the Tricare schedule ("Tricare limiting fee"). Tricare patients will need to waive these limitations and pay NIHA's full fee for any covered services' charges (due to NIHA services' uniqueness and rate), as well as for any non-covered Tricare services for which Tricare provides no reimbursement.

Claim Management: My treating practitioner(s) may respond to insurance requests for information but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to the patient upon the availability of the appropriate documentation. NIHA does not typically send information directly to insurance carriers due to problems it has experienced with carriers losing claims.

 Name_____

NIHA will provide a claim form (CMS 1500) for submission to insurance for licensed practitioners and special services such as IV or laboratory services for claims NIHA believes may be covered; submission shall be the patient's responsibility. NIHA reserves the right in preparing claim submissions to include those procedural codes or other data that accurately reflect services, and to invoice non-covered services using internal descriptions without the use of procedural codes. NIHA will make an effort to provide sufficient information to allow an insurer to determine what services it will reimburse but is not responsible for any insurance company decision. As NIHA does not participate with medical insurance it reserves the right to determine whether and how it will respond to insurance company requests for records. Patients may always obtain records and provide them in support of their claims. If possible, I understand that NIHA will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect.

Practice Responsibility: Each practitioner is responsible for his or her own care and the quality of care provided or directly ordered or supervised.
Arbitration: I understand that any disputes that may arise are subject to binding arbitration and will review and execute an agreement setting forth the terms.

No Guarantees: I am aware that no practice of medicine, dentistry or other healing art is an exact science and acknowledge that there are and can be no guarantees as to accuracy of any diagnosis or benefit or adverse response to treatments that I receive at NIHA.

Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Acknowledgment: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical/dental care and for no other purpose. I do not represent any third party. I agree that I will make no audio/video recordings within NIHA's offices.

Notice of Privacy Practices: I acknowledge that I have received and/or read a copy of NIHA's Notice of Privacy Practices.

Patient Contact/Messages: By my initials, I authorize NIHA staff to leave private or confidential health information messages on my voice mail, or with whomever answers, at the following telephone number(s): _____Home _____Cell _____Work
Further, I authorize protected health information to be sent to this e-mail address: _____

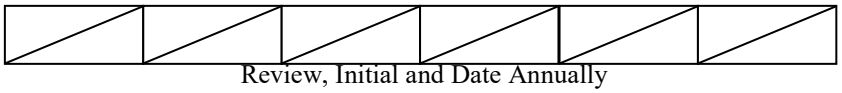
_____/date_____ _____/date_____
Signature of Patient or Legal Guardian Witness

Treatment Authorization and Agreement; I authorize medical/dental treatment of myself or my minor child by physicians, dentists or medical assistants and staff at National Integrated Health Associates. I understand the notices and agree to the policies, terms and conditions and releases of health information set forth in this Authorization and Acknowledgement. If I ever have any claim with respect to the services and treatment given to me by NIHA physician, practitioner or staff, that claim shall be judged by the standards and principles of complementary, alternative, or integrative medicine. I understand that this treatment may be administered by nursing or medical assistant staff.

In the event that the patient is a minor or under guardianship, I certify that I am the parent or legal guardian of the child/ward and that I have lawful custody for the purposes of authorizing health care consultations and for the release of protected health information. To the best of my knowledge, there is parental agreement about undergoing this consultation. In the event I am or become separated or divorced or any circumstances arise under which a parental disagreement over this authorization becomes an issue, I will indemnify and hold NIHA and its practitioners and staff harmless for any disputes that shall arise.

_____ _____
Patient Name/Parent Name (If applicable) Signature of Responsible Party

Annual Update Questions: Address, Telephone, email or Insurance Company Changes? If so, please update the information below.



Review, Initial and Date Annually

Date:_____ New address/phone #/email_____
_____
==========

Date:_____ New address/phone #/email_____
_____

Revised: 8/2018

National Integrated Health Associates, LLC (NIHA)
PAYMENT POLICY

Thank you for choosing our office. If you have any questions regarding fees for our services, please discuss them with us promptly and frankly. We will make every effort to avoid misunderstandings and preserve our relationship. In all cases, it is our intent to fully explain and inform you of all procedures, options and fees in advance of treatment. If you ever have questions or feel uninformed, please ask.

Payment is due in full at the time the treatment or service is started. Payment may be made with any combination of the following: cash, checks, MasterCard, Visa, and Discover. For your convenience we are able to arrange an extended payment plan through the use of Care Credit. Please feel free to request an application.

Medical Insurance
Our medical practitioners will provide you with a detailed invoice and a copy of their treatment notes, as needed, when you check-out. For services rendered that may be covered by an insurance plan, when you check-out we will provide you with the standard forms typically needed for filing a claim. Please be advised, however, that some of the services provided may not be covered by most insurance companies. Several practitioners and our Lab do not accept Tricare, while none of our practitioners or Lab accepts Medicare. We are sorry, but due to the time and difficulty involved in working with insurance companies we have to limit our involvement. However, for those carriers we do accept, we only file and follow-up insurance claims for our primary care practitioners. For all other practitioners, you will need to file your own medical claim and follow-up as needed.

Dental Insurance
Many of our dentists accept dental insurance plans and will file dental claims on your behalf. Benefit quotes from your insurance company are not a guarantee of payment. You are responsible for payment of all services rendered on your behalf or for your dependents. Payment is due at the time of service unless other arrangements have been made.

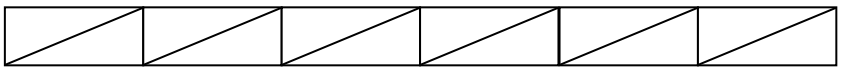
Missed Appointment Fee
To avoid incurring a missed appointment fee, a 48 business hours notice is required. Missed or broken appointments can interfere with your treatment plan, waste valuable staff time and raise everyone's fees. Our broken appointment policy is strictly enforced and is intended to prevent ALL patients from having to pay higher fees due to the behavior of a few. A broken appointment fee will range from $25 to $500 (up to 50% of the visit's fee).

Finance Fees and Charges
If you pay at the time services are rendered, there are no finance fees. If there is a balance on your account and it has not been fully satisfied within 30 days, you will be charged a monthly billing and interest fee at a rate of 1.5% per month on the outstanding balance. If your bank returns your check (due to insufficient funds or closed account) you will be charged $35.00 or our bank's current fee. If your account needs to be turned over to a third party for collection, there will be a charge of at least 50% of your total balance to cover attorney's fees and other collection costs.

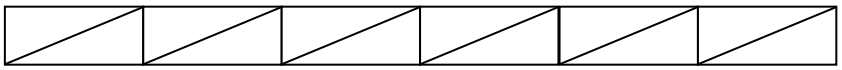
If you have any questions, PLEASE do not hesitate to ask us. We are here to help you.

I, _____, have read, understand and agree to comply with the above payment policy. I am providing my Social Security Number, _____, to assist with the payment process.

_____/ Date:_____
Signature of Patient or Legal Guardian


Renewal: Initial and Date

_____/ Date:_____
Witness


Renewal: Initial and Date

National Integrated Health Associates, LLC ("NIHA")
Patient/Client Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to professional malpractice, that is as to whether any professional services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, a violation of informed consent, wrongful death, or of emotional distress or punitive damages will be determined by submission to arbitration as provided by District of Columbia law, and not by a lawsuit or resort to court process except as District of Columbia law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by NIHA and by any practitioner or staff person, their partners, associates, associations, employees, agents and/or providers (hereinafter collectively referred to as "Practitioner") to a patient/client, including any spouse or heirs and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" or "client" herein shall mean both the mother and the mother's expected child or children. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (a) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable District of Columbia statute of limitations, or (b) the Patient or claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. Filing by Practitioner of any action in any court by the Practitioner to collect any fee from the patient/client shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Practitioner, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Practitioner, the amount of damages sought, and the names, addresses and telephone numbers of the patient/client, and (if applicable) his/her attorney. Within fifteen days after a party to this Agreement has given written notice to the other of demand for arbitration, the parties shall either determine a mutually acceptable arbitrator, or each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the arbitrator. Expenses of the arbitration shall be shared equally by the parties to this Agreement. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient/client shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to the District of Columbia Uniform Arbitration Act (D.C. Code § 16-4401-4432) and applicable arbitration requirements at D.C. Code § 16-2821 *et seq*. and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient/client intends this agreement to cover all services rendered by Practitioner not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Practitioner within 30 days of signature and if not revoked will govern all professional services received by the patient/client.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with District of Columbia law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I enter into this Agreement and I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF PROFESSIONAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND <u>YOU ARE GIVING UP YOUR RIGHT TO A JURY</u> OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ _____

Patient/Client Name (printed) Signature of Patient/Client/Authorized Rep. (and Relationship) Date

NIHA Representative Name Printed: _____ Signature: _____

National Integrated Health Associates, LLC

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

A. The General Authorization for Release of Medical Records that you sign authorizes the health care practitioners who provide services to you at NIHA, or NIHA acting on their behalf (collectively referred to as "Provider") to disclose the information in your medical records ("Protected Health Information" or "PHI") to the extent needed for purpose of:

1. Providing treatment to you. This includes sharing information among NIHA staff involved or who may become involved in your care, or with other health care providers in the community who are treating you or consulting in your care.
2. Arranging payment for your care. This includes your insurer, employer's health insurance program, or other third-party payer responsible for paying all or part of the cost of your care.
3. Supporting Provider's "health care operations." This includes internal quality assessment, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training health care practitioners, business planning and management, customer service, resolutions of internal grievances, the legal and medical review of care provided and provision of legal and auditing services.
4. Assisting other health care provider's "health care operations," to the extent that they have a treatment relationship with you.
5. In some cases, we may conduct research without revealing your identity.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes NIHA and NIHA practitioners you see to make a specific disclosure of PHI not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations you set forth regarding the disclosure of your records.

C. You may revoke any authorization given Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke General Authorization, and such revocation does not apply retroactively or to disclosure that has been made in good faith prior to receipt of the revocation.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are public health reporting requirements, responding to worker's compensation information, law enforcement or certain governmental requests involved in health care regulation including licensure agencies or the U.S. Department of Health and Human Services or national security, subpoenas in criminal or civil litigation.

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

F. Your rights and choices with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information, however we are not required to agree to restrictions not guaranteed by law if we believe it would affect your care. You will be informed if Provider will not agree to a requested restriction.
2. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will honor the request unless a law requires us to share that information.
3. You will have the right to receive confidential communications of your health information and to direct the place and manner of communication, such as by home or office phone or email.
4. You have the right to inspect your paper or electronic records and have a copy of your medical records. This will be done within 30 days of the request unless there is medical need for expedited copies. Provider is entitled to charge you a reasonable fee related to the cost of copying your records.

5. Requests to inspect or obtain copies of mental health records may be redacted if, in the Provider's opinion, the information would be damaging to you. If you disagree, you may request review by an independent mental health professional to determine if release of the information is appropriate.
6. You have the right to seek to correct or amend your medical records, and if Provider does not agree with your request, we will notify you within 60 days of the reason for the denial and will note your objection in the medical record.
7. You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider, for six years prior to the request, including with whom, the date and the purpose for sharing. The accounting does not include disclosures made to you or with your specific authorization, that fall within the scope of Provider's "health care operations, or disclosures made for the purposes of collecting payment. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
8. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will take reasonable steps to be sure the person has this authority and can act for you before we take any action.
9. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions:
   - Share information with your family, close friends, or others involved in your care
   - Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
10. We will never share your information for marketing purposes or sell your information unless we have written permission. We will not share psychotherapy notes unless a legal exception applies. In the case of fund-raising we may contact you for fundraising efforts, but you can tell us not to contact you again.
11. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate. In the event of a breach of security we will promptly advise you.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. Provider will not retaliate in any way against a patient for making a complaint. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Jason Makris, 202-237-7000 Ext. 102

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

National Integrated Health Associates
Dental History

Patient Name:_____ Date:_____

Date of ***last dental visit*** _____

Date of ***last cleaning***_____ Date of ***last X-rays*** _____

Previous dentist's name _____

Address _____

City / State / ZIP _____

How often do you have dental check-ups? _____

How often do you brush? _____ floss? _____

What dental aids do you use? _____

What dental problems do you have now? _____

Are any of your teeth sensitive to: (please circle)

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Do you get cold sores or other oral lesions? Yes No

Do you notice mouth odors or bad tastes? Yes No

Do your gums bleed or hurt? Yes No

Do you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught in your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Do you clench or grind while awake or asleep? Yes No

Do you mouth breathe while awake or asleep? Yes No

Have you noticed clicking or popping of the jaw? Yes No

Do you have difficulty opening or closing? Yes No

Do you have pain or difficulty chewing? Yes No

Do you have tired jaws, especially in the morning? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Rate your smile (on a scale of one to ten) _____

Would you like to keep all of your teeth for life? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Your teeth ground or bite adjusted? Yes No

Pain in jaw, joint, ear or side of face? Yes No

Sleep and Snoring Disorders

Do you use a CPAP machine? Yes No

Do you experience episodes of frequent snoring? Yes No

Do you experience episodes of Gasping when you are awaking from sleep? Yes No

Have you been told that you "Stop breathing when you are asleep? Yes No

Please rank the following in the order in which they would *KEEP YOU* from having treatment:

Fear of pain ____ Cost of treatment ____ Lack of concern ____

Missing time from work __ Embarrassed by dental condition ___