Louis R. Vita, D.D.S., F.A.G.D.

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We are pleased to welcome you to our practice and look forward to meeting you!

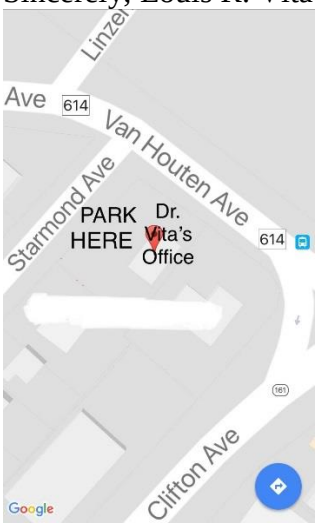
You have made an appointment for a consultation and exam to evaluate the current status of your temporomandibular joints (**TMJ**).

At this visit, Dr. Vita will address your current symptoms and examine your muscles, joints and bite relationship. Please bring all x-rays, MRI's and reports along with any bite guards that have been made for you to this visit. These will help in establishing an appropriate diagnosis. This visit will last approximately one hour. Then, additional 1-2 hours time following your visit is taken to review your case and generate a report of Dr. Vita's findings and recommendations. This report will be sent to all the doctors you have listed and you will also receive a copy.

Payment and Insurance:
The fee for the initial examination, review of records and report is generally **$350.00.** If your case is more complex and will require an extended time, the fee will be determined at the time of the visit. All services are payable at the time of service. This office does not accept insurance and we are out of network for all insurance carriers. We will however, file your **medical** insurance for your reimbursement.

We look forward to meeting with you and being able to discuss your concerns regarding TMJ dysfunction.

Sincerely, Louis R. Vita & Staff



VITA PAIN RELIEF CENTER
TMJ
REGISTRATION FORM

Date_____ Referred by_____

Patient_____ Date of Birth:___/___/___
(Last) (First) (M.I.)

Address_____
(City, State, Zip)

Home Phone:_____Cell Phone:_____

Email Address_____ SS#: _____

Employment Information

Name of Employer:_____Employer Address:_____

Phone #:_____Occupation: _____

Medical Insurance Information

Please have your card available for us to photocopy and complete below.

Subscriber's Name:_____ **Subscriber's** Date of Birth: ___/___/___

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Company Name: _____

Claims submission Address: _____
(City, State, Zip)

ID#: _____ Group #: _____

Do you have a secondary insurance? YES ☐ NO ☐ If yes, Complete below.

Subscriber's Name:_____ **Subscriber's** Date of Birth: ____/_____/_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name: _____

Claims submission Address: _____
(City, State, Zip)

ID#: _____ Group #: _____

NAME_____ **DATE**_____

Medical History

*Indicate which of the following you have had or have at the present: Circle Yes or No...

Heart Disease or Attack	yes/no	Tuberculosis	yes/no
Angina Pectoris	yes/no	Asthma/Emphysema	yes/no
Congenital Heart Disease	yes/no	Allergies/Hives	yes/no
Heart Murmur	yes/no	Sinus Trouble	yes/no
High Blood Pressure	yes/no	Radiation Therapy	yes/no
Heart Pacemaker	yes/no	Chemotherapy	yes/no
Heart Surgery	yes/no	Hepatitis A (infection)	yes/no
Rheumatic Fever	yes/no	Hepatitis B (serum)	yes/no
Drug Addiction	yes/no	Allergy to Latex	yes/no
Artificial Joints	yes/no	A.I.D.S.	yes/no
Kidney Trouble	yes/no	Cold Sores	yes/no
Ulcers	yes/no	Blood Transfusion	yes/no
Diabetes	yes/no	Anemia	yes/no
Thyroid Problems	yes/no	Sickle Cell Disease	yes/no
Glaucoma	yes/no	Liver Disease/Jaundice	yes/no
Cancer	yes/no	H.I.V. Positive	yes/no
Stroke	yes/no	Epilepsy or Seizures	yes/no
Fainting or Dizzy Spells	yes/no	Nervousness	yes/no

Do you have or had any disease, condition or problem not listed? Yes/No

If yes, please list:_____

Please list any and all medications taken daily with dosages:

_____

_____

_____

Are you allergic or sensitive to any medication or anesthesia? Please list:
_____
_____

Family Doctor:_____
_____
_____

*** Consent ***

I hereby understand that I have responsibly and truthfully disclosed the above information and I am responsible to inform the doctors of any changes in my medical status.

Patient Signature_____Date_____

VITA PAIN RELIEF CENTER

Problem Questionnaire

Name: _____Date:_____

1) Please list your chief complaints and concerns that bring you to our office.

_____

_____

_____

_____

_____

2) Is your pain constant? Yes/No If yes, where?

_____

3) Please describe when your pain began.

_____

_____

4) Please describe your pain and location.

( ) Throbbing_____

( ) Burning_____

( ) Stabbing_____

( ) Aching_____

5) **Please describe what makes your pain better or worse.**

_____

6) **Please describe the level of pain you currently have from 0 to 10**.
0 =no pain 10 = most severe

Location: Pain Level #:

Location: Pain Level #:

Location: Pain Level #:

Location: Pain Level #:

Location: Pain Level #:

7) **Do you sleep well or not?** Yes/No

If no, please explain._____

_____

8) **Do you clench or grind your teeth during the day or while sleeping?**

Yes/No

If yes, please explain._____

9) **Is there a condition or situation you would like to describe.**

_____

_____

VITA PAIN RELIEF CENTER

Event/Trauma History and Treatment

1) **Please list chronologically past history of events/traumas in your lifetime (examples: motor vehicle accidents, fall downs, whiplash, sports injuries, surgeries, orthodontics, braces, wisdom teeth extractions etc.) and the age at which the event/trauma took place.**

Event: Age:

Event: Age:

Event: Age:

Event: Age:

Event: Age:

Event: Age:

Event: Age:

2) **Please list all past treatments for your problems.**
(examples: night guards, dentist, chiropractor, physical therapist, neurologist, orthopedist, etc.)

Name_____

Please list all doctors **(names, complete addresses, and telephone numbers**) that have treated or examined you for this condition and **check those doctors you choose to receive a consultation report.**

Medical Doctor:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

Dentist:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

Specialist:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

Other:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

Other:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

Other:_____
_____

Treatment rendered:_____

Send Consultation Report: ☐

VITA HEAD, NECK & FACIAL PAIN RELIEF CENTER
Louis R. Vita, D.D.S., Angelo Colavita, DC, BCAO
991 Van Houten Avenue Clifton, NJ 07013

INFORMED CONSENT

I hereby authorize Dr. Vita and/or Colavita to examine me and suggest additional diagnostic testing. I understand that a patient seeking treatment at our office gives consent to his doctor to provide care in accordance with tests, analysis and diagnosis. It is rare that adjustments or other clinical procedures cause any problem, however, underlying physical defects, deformities and pathologies may render the patient susceptible to injury. The patient is responsible to truthfully disclose all pertinent information to the treating doctor regarding any illnesses, injury or adverse physical condition from which he/she is suffering or has experienced in their medical/dental history. While the doctor may advise the patient to seek diagnosis and treatment for a non-related condition, it remains the sole responsibility of the patient to do so.

The doctor and/or staff have advised me that this treatment regimen must be strictly followed. I agree that the doctor may terminate the doctor/patient relationship if he determines that I have not followed or am unlikely to follow the treatment regimen completely as it is critical to the success of my treatment. In the event that I am dismissed from care, or I, myself end treatment, it becomes my sole responsibility to seek and find treatment and further diagnostic testing from other healthcare providers. I will not hold the doctor of the Vita Head, Neck & Facial Pain Relief Center liable in any way whatsoever for such discontinued treatment or lack of follow up to another physician.

Neither the doctor nor any member of his staff has made any guarantees that his treatment will cure or benefit me in any way. I release the Vita Pain Relief Center, Dr. Louis Vita, Dr. Angelo Colavita and their staff and heirs from any and all claims or damages arising out of my treatment or omission to treat and diagnose, treatment outcome, or any aspect of care and result or lack thereof. I fully agree that I will not take any legal action against or toward Dr. Louis Vita, Dr. Angelo Colavita or their staff and heirs. I fully agree that I will not make negative or disparaging comments about any or all parties and care heretofore rendered. This includes written and verbal actions or comments.

I consent to have Dr. Vita/Dr. Colavita evaluate all of my available records and discuss with my physicians and dentists all past information that will assist in my care. I authorize Dr. Vita and/or Dr. Colavita to disclose any and all pertinent information to other healthcare providers and any other individual for my benefit within the confines of the Federal Privacy Practices Law. A copy of the Federal Privacy Practices Law is available at the office and will be furnished to me upon request at any time.

I give my permission to the doctors to share information about my case with other researchers as needed for statistical purposes and for possible scientific publication in medical journals. I also agree that my health information may be shared with governmental and/or regulatory agencies. I give my permission to Dr. Vita and/or Dr. Colavita to present my case, diagnosis and treatment outcome for teaching purposes and to include non-identifying photographs in presentation. I understand that in any publication, specific identifying information such as names and addresses will not be used. **(Patient's/Guardian's initials required)** _____

This office does not participate in any insurance plan other than Delta Dental for its dental patients only. Therefore payment will be made at the time of the service. Insurance reimbursement is solely and contractually between my insurance company and me. This office makes no claims of reimbursement from any insurance carrier for services rendered by the doctors. Payment for all services remains my sole responsibility. If I do not pay the provider's outstanding balance due and owing and the provider must send this matter to an attorney for collection, I agree to be responsible for reasonable attorney fees (to be calculated at the rate of 25% of the outstanding balance due and owing), costs of collection as well as interest charges (to be calculated at the rate of 1.5% per month for a total of 18% per annum. I also agree to be bound by the jurisdiction of the courts of the State of NJ.

I authorize the release and transmission of my medical records as required by my insurance company in order to process claims. I authorize this office to receive and accept payment directly from my insurance carrier in the event that I have not paid at the time of the service. I understand that my insurance will be filed by me and for my benefit only. This office does not guarantee reimbursement for any services rendered since this practice does not participate with my insurance plan.

I have read, understand and willingly consent by my signature below.

Patient Signature OR Guardian (if patient is under 18 years old) Date

Patient Name (Please print clearly) Guardian Name (Please print clearly, if patient is under 18 years old)

Patient HIPAA Awareness

With my permission, Dr. Louis Vita and/or Dr. Angelo Colavita may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Louis Vita's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Louis Vita and/or Dr. Angelo Colavita reserve the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Louis Vita/Dr. Angelo Colavita may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Louis Vita/Dr. Angelo Colavita may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Louis Vita and/or Dr. Angelo Colavita restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Louis Vita and/or Dr. Angelo Colavita to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian Date