Please complete all sections as thoroughly and accurately as possible. Be sure to include all required dates and signatures. Your information is kept private and helps us provide you with the best possible care.

DATE:

Patient Demographics:

First name _____ Last name _____ (MI) _____

Preferred name _____ DOB _____ Gender _____

Street address _____ City, state, zip _____

Email: _____ SS # (last 4) _____

Cell phone # _____ Home phone # _____

Marital status _____

Emergency contact #1 _____ Relation _____ Phone #_____

Emergency contact #2 _____ Relation _____ Phone # _____

Please list the names of any healthcare providers authorized to receive or discuss your protected health information:

Referring physician/dentist _____ Phone #_____

_____ _____

_____ _____

Please describe the reason for your visit:

_____

_____

Medication Allergies:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications: Please list all current medications. A separate medication list may be provided.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social history:

Caffeine Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Tobacco Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you use any illicit or recreational drugs? ☐ Yes ☐ No

Are you currently experiencing unusual stress? ☐ Yes ☐ No

Have you experienced any recent lifestyle changes? ☐ Yes ☐ No

Medical History: Please check all that apply

General & Neurologic

☐ ADHD
☐ Autism
☐ Anxiety
☐ Depression
☐ Mental illness (other)
☐ Headaches / Migraines
☐ Seizures / Epilepsy
☐ Stroke / TIA
☐ Vestibular dysfunction / dizziness
☐ Meniere's disease
☐ PTSD
☐ Somatic symptom disorder
☐ Head trauma / injury

Musculoskeletal & Pain

☐ Arthritis
☐ Fibromyalgia
☐ Chronic pain
☐ Back injury
☐ TMJ disorder / jaw pain
☐ Muscle, joint, or bone problems
☐ Hypermobility disorder
☐ Ehlers-Danlos syndrome
☐ Osteoporosis
☐ Neck pain

Cardiovascular

☐ Heart disease
☐ Coronary artery disease
☐ Congestive heart failure
☐ Arrhythmia (irregular heartbeat)
☐ High cholesterol
☐ Hypertension (high blood pressure)

Respiratory

☐ Asthma
☐ COPD
☐ Lung disease
☐ Sleep apnea

Gastrointestinal

☐ GERD / Reflux
☐ Irritable bowel syndrome (IBS)
☐ Diverticulitis
☐ Ulcers
☐ Difficulty swallowing
☐ GI problems (other)

Endocrine & Metabolic

☐ Diabetes
☐ Thyroid problems
☐ Hypothyroidism
☐ Hormonal imbalance
☐ Hyperthyroidism
☐ Hashimoto's

Autoimmune & Inflammatory

☐ Autoimmune disease
☐ Allergies / Hay fever
☐ Chronic fatigue syndrome
☐ Skin problems

Hematologic & Infectious

☐ Anemia
☐ Bleeding disorder
☐ Blood disease
☐ Hepatitis
☐ HIV / AIDS

Genitourinary

☐ Kidney disease
☐ Kidney stones
☐ Bladder or kidney problems

Ear, Eye, and Sensory

☐ Ear or hearing problems
☐ Vision or eye problems

Other Medical Conditions

☐ Cancer
☐ Birth defects
☐ Liver disease
☐ POTS (Postural Orthostatic Tachycardia Syndrome)
☐ Anesthesia complications
☐ Gout

Women's Health

☐ Pregnant
☐ Breastfeeding

☐ **Other condition(s) not listed:**

_____

Please add any additional information you feel is relevant:

_____

_____

_____

_____

Phq-9 Questionnaire

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Brief Environmental Exposure and Sensitivity Inventory

Instructions: Please answer these three questions by checking Yes or No

1. Do you feel sick when you are exposed to tobacco smoke, certain fragrances, nail polish/remover, engine exhaust, gasoline, air fresheners, pesticides, paint/thinner, fresh tar/asphalt, cleaning supplies, new carpet or furnishings? By sick we mean: headache, difficulty thinking, difficulty breathing, weakness, dizziness, upset stomach, etc.

❑*Yes* ❑*No*

2. Are you unable to tolerate or do you have adverse or allergic reactions to any drugs or medications (such as antibiotics, anesthetics, pain relievers, X-ray contrast dye, vaccines or birth control pills), or to an implant, prosthesis, contraceptive chemical or device, or other medical/surgical/dental material or procedure?

❑*Yes* ❑*No*

3. Are you unable to tolerate or do you have adverse reactions to any foods such as dairy products, wheat, corn, eggs, caffeine, alcoholic beverages, or food additives (e.g., MSG, food dye)?

❑*Yes* ❑*No*

Five-Part Questionnaire for Identifying Hypermobility

1. Can you now (or could you ever) place your hands flat on the floor without bending your knees? O Yes O No
2. Can you now (or could you ever) bend your thumb to touch your forearm? O Yes O No
3. As a child did you amuse your friends by contorting your body into strange shapes

   Or could you do the splits? O Yes O No
4. As a child or teenager did your shoulder or kneecap dislocate on more than one occasion? O Yes O No
5. Do you consider yourself double-jointed? O Yes O No

Consent for AI Assisted Documentation

To help us focus more on you and less on paperwork, Dr. Robinson-Smith uses a secure, HIPAA-compliant AI assistant to help document your visit. This technology allows Dr. Robinson-smith to capture important details of your appointment through voice dictation, improving accuracy and efficiency in your medical record.

What this means for you:

- The AI system listens during your visit to help create clinical notes.
- Your information is used only for your medical care and documentation.
- No information is sold or used for marketing purposes.

Your privacy is protected:

- Your information is encrypted and securely stored.
- The system meets strict healthcare privacy and security standards.
- Additional safeguards are in place to monitor for and prevent unauthorized access.

Participation is completely optional. Your care will not be affected in any way if you choose not to have this technology used during your visit.

If you have any questions, please let us know—we're happy to help. You can also learn more at www.suki.ai.

Please initial your preference:

I consent to the use of AI-assisted documentation during my visit: _____

I prefer not to have AI-assisted documentation used: _____

Consent For Treatment of Orofacial Disorders and Other Disorders of The Head and Neck

Orofacial pain disorders mimic other dental and medical problems. In some cases, symptoms like headaches or neck pain may be related to more serious health conditions. Because of this, an accurate diagnosis is very important.

Length of treatment: Treatment time can vary widely from person to person. In general, care may take longer and be more involved if symptoms are severe or have been present for a long time.

Some mild conditions—may improve within a few weeks to months. More complex or long-standing conditions, such as joint arthritis or damage, may require more comprehensive care, including dental treatments or, in some cases, surgery.

Patients with additional or coexisting health conditions (comorbidities) may experience more complex symptoms and require a more individualized and coordinated approach to care.

In certain situations, symptoms may temporarily worsen during treatment, especially for patients with chronic joint disease, degenerative conditions, prior injuries, or other underlying health issues.

Our goal is to diagnose and treat your condition as efficiently and cost-effectively as possible, using conservative, evidence-based approaches whenever appropriate. However, it is important to understand that there can be differences of opinion within the medical and dental community about the best treatment methods or combinations of care.

Off label treatment disclosure: Because of the specialized nature of orofacial pain and TMJ care, some treatments we use are considered "off-label." This means the treatment is supported by research and clinical experience but was originally developed or approved for a different condition or part of the body.

For example, some therapies used for TMJ disorders were first studied in larger joints, like the knee, where more research has been conducted. Even though these treatments were not specifically designed for the TMJ, they are commonly used and considered safe and effective.

If you have any questions about what off-label treatment means or how it applies to your care, please feel free to ask.

Patient responsibility: You can help us provide the best care by sharing a complete medical and family history, including all medications, supplements, and any food or drug allergies.

Treatment for these conditions can take time and may sometimes feel frustrating. It is important to let us know about any changes in your symptoms, or overall condition.

The best results come from open and ongoing communication between you and your provider.

I confirm that I have read, or had explained to me, the consent for treatment of orofacial pain and head and neck disorders, including the off-label treatment disclosure. I understand the information provided, have had the opportunity to ask questions, and consent to evaluation and treatment.

Printed name of patient or personal representative: _____

Signature: _____ Date: _____

If signed by personal representative, please describe authority: _____

Office Policies

Thank you for choosing us for your care. We are committed to building a strong and successful relationship with you.

A clear understanding of our office policies helps us provide you with the best possible care and service.

Please take a moment to review this information carefully, and feel free to ask any questions if anything is unclear.

Please initial each section to confirm you have reviewed and understand this policy.

Insurance **Initials: _____**

Orofacial Pain Associates and Dr Robinson-Smith are not in-network with any insurance plans. Payment is due in full at the time of your visit.
If you wish to seek reimbursement from your insurance company, we are happy to provide a superbill upon request for you to submit. Depending on your plan, you may receive partial reimbursement for out-of-network services.
If you are a Medicare or Medicaid beneficiary and choose to receive care at Orofacial Pain Associates you will be required to sign a private contract. This agreement states that:

- Medicare or Medicaid will not pay for services provided
- You agree not to submit claims to Medicare or Medicaid
- You accept full financial responsibility for all services
- Payment is due in full at the time care is provided

Please note:

- We do not submit insurance claims on your behalf
- We do not accept single case agreements
- Our office is not involved in disputes with insurance companies, including issues related to coverage, eligibility, coordination of benefits, pre-existing conditions, or claim denials

Laboratory tests, imaging, and medication ordered by Dr Robinson-Smith are often covered by insurance plans, even if your provider is out-of-network. However, coverage varies. Please verify your benefits and coverage with your insurance company prior to receiving these services.

Why insurance is not accepted:

This decision allows us to focus on providing high-quality, individualized care without the limitations often imposed by insurance companies.
Insurance reimbursement for complex, time-intensive conditions—such as orofacial pain and TMJ disorders—is often limited and may not reflect the level of care required. In many cases, insurance plans also place restrictions on the time spent with patients and the types of treatments that are covered.

By remaining out-of-network, we are able to:

- Spend more time with each patient when needed
- Focus on thorough evaluation, education, and personalized treatment planning
- Use evidence-based approaches tailored to your specific condition
- Avoid limitations that may interfere with clinical decision-making

Our priority is to provide care based on what is most appropriate for you, rather than what is dictated by insurance coverage.

Payment **Initials: _____**

Payment is due at the time of your appointment unless other arrangements have been made in advance. Any alternate financial arrangements must be discussed and agreed to in writing prior to your visit.
Appointments that are not paid for on the day of service will incur a $50 fee.

Accepted Forms of Payment:
- Credit and debit cards (Visa, Mastercard, American Express, Discover)
- CareCredit
- Cherry Financing
- Checks (typically deposited the same or next business day. A $50 fee will be applied to your account for any returned check, in addition to the original amount owed.)
- Cash is accepted only if the exact amount is provided, as we are unable to make change.

We do not offer in-house payment plans. However, we partner with Cherry Financing, which may provide flexible payment options for eligible patients.

Office Fees **Initials: _____**

A list of our current office fees is available at any time upon request.
Fees may be adjusted periodically due to increases in operating costs.
If your appointment was scheduled well in advance, we recommend contacting our office prior to your visit to confirm current fees.

Outstanding Balances **Initials: _____**

All outstanding balances must be paid in full prior to receiving additional treatment.
Statements for any unpaid balances are mailed during the first week of each month. Payment is due in full within 30 days of the statement date.
A $50 late fee will be applied to any balance not paid within 30 days.
The parent(s) or guardian(s) accompanying a minor and signing this policy and/or consent for treatment are considered the financial guarantor and are responsible for all charges.
A maximum of three (3) statements will be issued.
If payment is not received within 90 days, the account may be referred to an outside collection agency, and the patient may be dismissed from the practice.
If an account is sent to collections, the financially responsible party agrees to pay all associated costs, including but not limited to collection fees, attorney fees, and court costs.
Patients age 18 and older are financially responsible for their own care.

Appointments **Initials: _____**

Appointments are required for all visits. Because many of our patients have complex conditions, some individuals may require longer or more frequent appointments to fully address their concerns.
Dr. Robinson-Smith strives to make each visit as productive as possible by providing thorough education, answering questions, and discussing personalized management strategies as part of your care.
If you have an urgent concern, please contact our office as early as possible in the day to request a same-day appointment. While same-day appointments cannot be guaranteed, we will make every effort to accommodate you in a timely manner.
For medical emergencies, please call 911 or go to the nearest emergency room.

Communication **Initials: _____**

Our office voicemail is monitored seven (7) days per week. You may leave a message, and your call will be returned. For urgent matters, please allow up to 24 hours for a return call. Non-urgent calls will be returned on the next business day. Dr. Robinson-Smith reserves the right to charge for telephone calls that involve evaluation and management of your medical condition.

If you prefer an alternate method of communication, you may send a secure message through the patient portal (preferred) or through the "Contact Us" section of our website. While our email system is encrypted and HIPAA-compliant, communication through the patient portal is encouraged so that messages can be documented as part of your medical record. Please be aware that responses to portal or email messages may take up to 72 hours or longer in certain circumstances, such as provider absence or emergencies.

Electronic communication is intended for non-urgent, non-complex, and administrative matters only. These methods should not be used for emergencies. If you are experiencing new or worsening symptoms, you must be evaluated in person. For urgent or emergent concerns, please call 911 or go to the nearest emergency room. If you have a complex medical question or concern, please schedule an appointment.

For your privacy and security, standard unsecured email is not considered a HIPAA-compliant method of communication. Although our office uses encrypted email, the patient portal remains the preferred method for sharing protected health information.

Late Arrival **Initials:**

If you arrive late for your scheduled appointment, you may be seen for the remaining portion of your appointment time and will be charged for the full appointment. The ability to be seen after a late arrival will be determined on a case-by-case basis, and you may be asked to reschedule.

Late Cancellations and Missed Appointments **Initials: _____**

Our practice has implemented this policy to ensure that appointment times remain available for patients in need of care. Missed appointments and late cancellations result in lost time that cannot be offered to other patients and create significant costs for our office. We understand that emergencies and unexpected obligations may arise, and exceptions may be considered at the discretion of the practice.

Appointments must be cancelled with at least 48 hours' notice. A late cancellation is defined as cancelling an appointment with less than 48 hours' notice. Late cancellations will result in a fee of $25 for a standard visit and $50 for visits involving a procedure. A same-day cancellation is defined as cancelling on the day of the appointment or failing to appear without notice (no-show).

Procedures require additional scheduling coordination and preparation. These appointments may not be cancelled or rescheduled with less than 7 days' notice. Failure to provide adequate notice will result in forfeiture of any deposit.

Repeated missed or same-day cancelled appointments will require a deposit to schedule future visits. After the third same-day cancellation, a $50 non-refundable deposit will be required. After the fourth, a $100 non-refundable deposit will be required. After the fifth, payment in full (100%) will be required as a non-refundable deposit to schedule future appointments. Deposits will be applied toward the cost of the scheduled appointment if attended but will be forfeited if the appointment is missed or cancelled the same day.

Patients who repeatedly cancel appointments without appropriate notice may be subject to dismissal from the practice.
We appreciate your understanding and cooperation in helping us provide timely, high-quality care to all patients.

Medical Records **Initials: _____**

We are committed to protecting the privacy of your protected health information (PHI). Written authorization is required for the release of medical records, except as permitted by law. Requests for records are typically processed within 5–10 business days.
Your signature below authorizes this office to use and disclose the minimum necessary medical information for purposes of treatment, payment, and healthcare operations, including submission of information to your insurance company for claims processing initiated by the patient.
You understand that you may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Medication Refills **Initials: _____**

Please contact our office directly for all prescription refill requests.

For compounded medications, we recommend requesting a refill at least 7 days before running out, as additional time is required for the pharmacy to prepare these medications. For non-compounded medications, refill requests may take 3–5 business days to process. Please plan accordingly to avoid interruptions in your medication.

Refill requests may not be approved if you have not been evaluated by your provider within the past 3–6 months. In some cases, a limited or partial refill may be provided for urgent needs, with the understanding that an appointment will be required before additional refills are authorized. No medications will be refilled for patients who have not been seen in the office within one (1) year.

Patients prescribed controlled medications are required to be seen in the office at least every 90 days to continue receiving refills and must have a signed pain management agreement on file.

In accordance with Colorado law, prescribing of controlled substances may include review of the Prescription Drug Monitoring Program (PDMP), periodic reassessment of treatment effectiveness and safety, and may require urine drug screening or other monitoring measures. Controlled substances will be prescribed only when medically appropriate and in compliance with all applicable state and federal regulations.

Patients receiving controlled medications agree to obtain prescriptions only from this office for the conditions being treated, unless otherwise authorized, and to use one designated pharmacy whenever possible. Patients must inform the office of any controlled substances prescribed by other providers.

Interstate Care Policy **Initials:**

Dr. Julie Robinson-Smith evaluates patients from out of state and outside the United States; however, in accordance with Colorado licensing requirements, all initial visits must be conducted in person at her office in Colorado Springs, Colorado.

Telehealth services are not available. Ongoing care requires in-person follow-up visits at intervals determined by the Dr Robinson-Smith. Communication outside of scheduled visits is limited, does not constitute a clinical evaluation, and is not a substitute for an in-person examination.

Care provided by Dr. Robinson-Smith is considered to occur within the State of Colorado. Communication with patients located outside of Colorado does not establish a provider-patient relationship in any other state or jurisdiction and does not constitute the practice of medicine outside of Colorado. Patients are responsible for maintaining a local healthcare provider for urgent, emergent, or ongoing medical needs. Dr. Robinson-Smith may communicate with your local provider for coordination of care when appropriate; however, such communication must be initiated by your local provider and may occur via telephone or secure email.

Office Policy Acknowledgement, Authorization, and Consent

If you have any questions regarding our office policies, please feel free to ask.

I acknowledge that I have read and understand the office policies and my responsibilities as a patient of Orofacial Pain Associates. By signing below, I agree to comply with and accept the terms and conditions outlined above.

I authorize Dr. Julie Robinson-Smith to provide evaluation and treatment. I also authorize the release of the minimum necessary medical information to support insurance claims submitted by me or on my behalf.

Printed name of patient or personal representative: _____

Signature: _____ Date: _____

If signed by personal representative, please describe authority: _____

Acknowledgment Of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices for Orofacial Pain Associates. This Notice describes how my health information may be used and disclosed and outlines my rights regarding my health information.
I understand that I have the right to review this Notice in full and to ask questions about its contents. I have been given the opportunity to ask questions and receive answers to my satisfaction.
I understand that I may request a paper or electronic copy of the Notice at any time.

Patient Information
Patient Name: _____
Date of Birth: _____

Signature
Signature of Patient or Personal Representative: _____
Date: _____
If signed by Personal Representative, describe authority: _____

FOR OFFICE USE ONLY
We made a good faith effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices.
☐ Patient received and signed acknowledgment
☐ Patient refused to sign
☐ Unable to obtain acknowledgment (reason): _____
Staff Name: _____
Staff Signature: _____
Date: _____

Medication History Authority

This authorization allows Orofacial Pain Associates to obtain and review your medication history from external sources to support safe, accurate, and effective medical care.
Medication history may include information about prescriptions you have filled, including medication names, dosages, prescribing providers, and dispensing pharmacies.

AUTHORIZATION FOR USE AND DISCLOSURE: I authorize Orofacial Pain Associates and its providers, staff, and authorized agents to request, access, use, and disclose my medication history from and to:

- Pharmacies and pharmacy benefit managers (PBMs)
- Health plans and insurance companies
- Electronic prescribing networks (including Surescripts or similar networks)
- Health Information Exchanges (HIEs)
- Other healthcare providers involved in my care

This information may be obtained electronically or through other lawful means.

PURPOSE OF DISCLOSURE: My medication history will be used for:

- Treatment and care coordination
- Medication reconciliation and patient safety
- Clinical decision-making
- Preventing drug interactions, duplications, or adverse events

SCOPE OF INFORMATION: This authorization includes, but is not limited to:

- Current and past medications
- Dosage, strength, and quantity
- Dates of fill and refill history
- Prescribing provider information
- Pharmacy information

This may include sensitive health information if it is part of my medication history.

SPECIAL PROTECTIONS: Some medication information may relate to conditions that receive additional privacy protections under federal or state law, including:

- Substance use disorder records protected under 42 CFR Part 2
- Mental health information
- HIV/AIDS-related information

Such information will only be disclosed in accordance with applicable laws and, where required, with my specific consent.

VOLUNTARY AUTHORIZATION: I understand that:

- This authorization is voluntary
- I may refuse to sign this authorization
- My refusal will not affect my ability to receive treatment, payment, enrollment, or eligibility for benefits, except where medication history is necessary for safe care
-

RIGHT TO REVOKE: I may revoke this authorization at any time in writing by contacting Orofacial Pain Associates. Revocation will not apply to information already obtained or disclosed in reliance on this authorization.

EXPIRATION: This authorization will remain in effect until the earliest of the following:

- One (1) year from the date of signature
- The end of my course of treatment with Orofacial Pain Associates
- Revocation by me in writing

REDISCLOSURE NOTICE: Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, except where otherwise restricted by law (including 42 CFR Part 2).

ACKNOWLEDGEMENT

I have read and understand the Medication History Authority authorization. I have had the opportunity to ask questions. I authorize the use and disclosure of my medication history as described above.

Printed name of patient or personal representative: _____

Signature: _____ Date: _____

If signed by personal representative, please describe authority: _____

NO ASSIGNMENT OF BENEFITS (AOB)

I understand and agree to the following:

This provider is a non-participating provider and does not accept assignment of insurance benefits.

I am not assigning, transferring, or conveying my right to receive insurance reimbursement to the provider.

All payments for services are my sole responsibility, regardless of insurance coverage or reimbursement.

The provider will not submit claims to insurance carriers and will not accept direct payment from any insurance company on my behalf.

If any insurance payment is made directly to the provider, I acknowledge that such payment may be returned to the payer or redirected to me, consistent with office policy and applicable law.

Printed name of patient or personal representative: _____

Signature: _____ Date: _____

If signed by personal representative, please describe authority: _____