THE DENTAL ANESTHESIA CENTER
Office: 314-862-7844
www.dentalsleepstlouis.com

Welcome!
Whom may we thank for referring you?

_____ Date _____

☐ Adult Patient ☐ Child/Adolescent Patient ☐ Special Needs (lives with parents/guardian)

Patient: First Name_____ Last Name_____ MI_____

Billing Address_____ City _____ ST_____ Zip_____

Sex: ☐M ☐F Birthdate _____ SS#_____ Email_____

Cell # _____ Work _____ Pharmacy Name/Ph# _____

Marital Status (Insurance purpose) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parents: (For consent/billing purposes of children under 26 or specials needs dependents)

Who has legal custody for health/dental/financial decisions? ☐ Married ☐ Mother ☐ Father ☐ Joint ☐ Other

Mother _____ Date of Birth_____ Cell# _____ SSN_____

Address _____ City _____ ST_____ Email_____

Father _____ Date of Birth_____ Cell# _____ SSN_____

Address _____ City _____ ST_____ Email_____

BILLING INFO and SIGNATURE ON FILE

I authorize the release of ANY information to all claims for benefits submitted for myself and my dependents. I agree and acknowledge my signature authorizes my dentist to submit claims for services or services to be rendered, without obtaining my signature on every claim to be submitted for myself and my dependents. I will be bound by this signature as through I, the undersigned, signed each claim. Furthermore, I authorize direct assignment of benefits to all claims to my dentist.

X _____ /X_____

Authorized signature for **PRIMARY** dental insurance Authorized signature for **SECONDARY** dental insurance

Primary DENTAL Insurance Co. Name: _____ Phone _____

Primary DENTAL Insurance Co. Address: _____

Primary Employer (Group name) _____

Primary Employer (Subscriber name) _____ **Birth date** _____

Primary Policy Holder SS# _____ **ID#** _____ **Group#** _____

Secondary DENTAL Insurance Co. Name: _____ Phone _____

Secondary DENTAL Insurance Co. Address: _____

Secondary Employer (Group name) _____

Secondary Employer (Subscriber name) _____ **Birth date** _____

Secondary Policy Holder SS# _____ **ID#** _____ **Group#** _____

Emergency Contact_____ **Relation**_____ **Phone**_____

I agree it is my responsibility as the Patient, Parent or Guardian to assure my dentist of complete and prompt payment regardless of insurance limitations or denials. Refusal to do so may result in late charges and further collection process.

X _____

HEALTH HISTORY FORM

Name _____ Weight _____ Height _____ BMI_____

Birthdate _____

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch in-between your teeth?	☐	☐
Have you ever had periodontal (gum) therapy?	☐	☐
Have you had dental surgery?	☐	☐
Do you wear partials or dentures?	☐	☐
Is your mouth dry?	☐	☐
Do you use hard candy/throat lozenges daily?	☐	☐
Are you on a special diet?	☐	☐
Do you drink energy drinks, soda, sweetened tea/coffee?	☐	☐
Is bottled/filtered or well water your main source of water?	☐	☐
Have you ever had braces?	☐	☐
Do you have earaches or neck pain?	☐	☐

	Yes	No
Do you have clicking, popping or discomfort in the jaw?	☐	☐
Do you grind your teeth?	☐	☐
Have you had cold sores in the mouth or on the lips?	☐	☐
Do you participate in active sports/recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐
Are you currently experiencing dental discomfort/pain?	☐	☐
Have you ever had a negative dental experience?	☐	☐

If yes, please explain _____

_____

What is the reason for your visit today? _____

Date of last dental exam _____ date of last x-rays _____

Previous Dentist name _____

MEDICAL INFORMATION

	Yes	No
Are you currently under the care of a physician/specialist?	☐	☐
Are you taking any medications?	☐	☐

If yes, what condition is being treated? _____

_____

If yes, please provide a medication list.

_____

_____

Physician Name _____

Date of last physical exam _____

Physician Phone _____ Fax _____

Pharmacy Phone _____

	Yes	No
Have you had a serious illness, operation, joint replacement or hospitalization in your lifetime?	☐	☐
Do you have dental phobia or anxiety?	☐	☐
Do you have gag reflex?	☐	☐
Do you or your family members have a history of anesthesia problems?	☐	☐

If yes, please explain. _____

_____

_____

Explain _____

_____

_____

The answers to the following questions are relevant due to any medication or sedation we may prescribe for you.

	Yes	No
Do you wear contact lenses?	☐	☐
Do you currently take any GLP-1 analogs such as Ozempic (Semaglutide), Trulicity (Dulaglutide), Victoza (Liraglutide), Mounjaro (Tirzepatide), etc. for Diabetes or weight loss?	☐	☐
Are you taking or have you ever taken medications for osteoporosis, bone disease, bone cancer including Bisphosphonates?	☐	☐
Do you use recreational drugs?	☐	☐

If yes, please list. _____

Date Treatment began _____

If yes, specify: _____

_____

_____

	Yes	No
Do you currently use, or have you ever used tobacco products (smoking, snuff, chew, vaping)?	☐	☐
If so, how interested are you in stopping?	☐	☐
Do you drink alcoholic beverages?	☐	☐
WOMEN ONLY Are you:		
Pregnant?	☐	☐
Taking birth control pills or hormone replacement?	☐	☐
Nursing?	☐	☐

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much alcohol do you typically drink in a week? _____

Number of weeks _____

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No
Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Adhesive Tapes _____	☐	☐
Metals _____	☐	☐
Latex (Rubber) _____	☐	☐
Iodine _____	☐	☐
Hay fever/seasonal _____	☐	☐
Animals _____	☐	☐
Food _____	☐	☐
Other _____	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Artificial (Prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date: _____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
If yes, specify: _____		
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers (stomach)	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Sleep disorder/ sleep apnea	☐	☐
If yes, please specify: _____		
Mental health disorders	☐	☐
Specify: _____		
Neurological or Genetic disorders	☐	☐
If yes, specify: _____		
Recurrent infections	☐	☐
Type of infection: _____		
Kidney problems	☐	☐
Excessive urination	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
If yes, please specify type: _____		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Name of physician or dentist making recommendation: _____ Phone _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above information given on this form is accurate. I understand the importance of a truthful health history and my dentist and his/her staff will rely on this informaiton for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action taken or not taken because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Print Name: _____ Date: _____

THE DENTAL
ANESTHESIA CENTER

Patient Name:_____ **Date:**_____

Expires in 1 year

Acknowledgment – Receipt of Notice of Privacy Practices (HIPAA)

We are required by law to provide you with a copy of our Notice of Privacy Practices, which explains your rights and our legal duties covering your protected health information and how we may use and disclose your protected health information.

Name of Person(s) The Dental Anesthesia Center can disclose your protected Health and Dental information with:

_____

_____

_____

Other Methods of Communication

You may ask us to communicate with you by other methods. I request to receive/release communication of my protected health information by any of the methods described below.

U.S. Mail / Home, Work, Cell Phone / Answering Machine / E-mail / Text Message

Acknowledge by Patient/Personal Representative(s)

If you are the Patient or a Personal Representative acting on the behalf of the patient, please check the appropriate box below and sign at the bottom of the form. Proof of your authority to act may be requested.

I received the Notice of Privacy Practices of The Dental Anesthesia Center.

❑ Self ❑ Guardian ❑ Parent ❑ Support Staff: (Name/Title: _____)

X _____

Signature Printed Name

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Name_____

Sleep Apnea Risk Questionnaire

Instructions: Please circle yes or no to the following questions.

Q. Have you previously been diagnosed with Obstructive Sleep Apnea? Yes No

If yes, are you satisfied with current treatment? Yes No

If not diagnosed, answer questions 1 through 4

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1. **S:** Do you snore loudly?
(louder than talking or LOUD enough to be heard through closed doors) Yes No

2. **T:** Do you often feel tired, fatigued or sleeping during the daytime? Yes No

3. **O:** Has anyone observed you stop breathing during your sleep? Yes No

4. **P:** Do you have or are you being treated for high blood pressure? Yes No

For office use only:

B: *BMI>35*
A: *Age>50*
N: *Neck>17 Inches Male*
16 Inches Female
G: *Male?*

STOP≥2 yes = high risk OSA
STOP-Bang≥3 = high risk OSA