950 Francis Place, Suite 305
St. Louis MO, 63105
Office: 314-862-7844
www.sleepdentistrystlouis.com

Welcome to The Dental Anesthesia Center!

REGISTRATION for Special Needs/ Disabled Patients:

Special Needs and Disabled Patients are often unable to cooperate to have their dental care completed. We understand the challenges they face and we are committed to removing the barriers that prevent them from receiving the care they need.

Please complete the enclosed forms **PRIOR** to the first visit and bring them with you. **We need the patient's medical diagnosis, medical history, allergies, and sensitivity to anesthetic. Bring a separate list of all medications** including over the counter. These forms are important to determine the course of treatment.

Also included, will be forms requesting information pertaining to **the patients physical address, legal guardianship, person responsible for payment, their address and contact information, and HIPAA release.**

Upon conclusion of the exam, we will provide a basic treatment plan estimate (exam, x-rays, cleaning, fluoride) and suggest a sedation plan as the safest solution for the patient. This will be given to the accompanying caregiver so funding can be requested from the appropriate party. If the patient is unable to cooperate, the findings of the examination may be limited and there may be unexpected changes during the course of treatment.

Availability of funds per patient may vary and we do not wish to exceed that patient's limit. Once the funds are acquired, a sedation appointment will be scheduled. During the course of treatment, **if there are changes or additional findings, we will need to know how much of the additional treatment should be completed. Please inform the accompanying caregiver of this patient's financial threshold in the event there are changes or additional findings.**

Due to the extended wait to obtain an appointment, **we require a 72 hour verbal confirmation for all scheduled appointments.** The courtesy of extending an unwanted or unneeded appointment may benefit another patient who is in need of care. **If verbal confirmation is not returned, the appointment may not be reserved.**

If you have any questions, we may be reached at 314-862-7844.

Explanation of Letter of Medical Necessity

Many of our patients have special needs that require deep sedation or general anesthesia to cooperate for dental care. Some insurance companies may consider reimbursement for sedation services for children under the age of five, a person severely disabled or a person with a medical, mental or behavioral condition.

Claims submitted for reimbursement require a **letter of medical diagnosis and necessity from your physician**. This letter must be on the **physicians' company letterhead with the physicians signature.**

Please complete this **PRIOR** to your first visit with us. You may bring it with you or it can be faxed to 314-862-4504. It can also be emailed to secure@dac950.com.

Below is an example of what your physician must include in the letter.

Sincerely,

Cheri Williams
Insurance Manager

Example:

DATE:__________

(Name) has been diagnosed with (medical condition). (Name) will require sedation services as it is medically necessary for dental care to be completed.

Welcome! Whom may we thank for referring you?

______________________________ Date__________

We realize our dependent patients have different supported living arrangements. It is the responsibility of the parent, guardian or supported living organization requesting care to assure complete and prompt payment. Who is accompany Patient today? ______________________________

PATIENT: First Name____________________ Last Name____________________ MI ____

Sex: ____M ____F Birthdate ______________ SS# ____________________

Resides at: ______________________________City ____________ ST _____ Zip ________

FOR CONSENT:

Birth Mother________________________ Cell#______________ Email ______________

Birth Father ________________________Cell#______________ Email ______________

CONTACT INFO: Guardian(s) name if different than Parent ______________________

Relationship to Patient____

Phone#____________________ Fax#__________________ Email____________________

Name of facility/support living organization ______________________________

Address for billing __________________________City____________ ST _____ Zip ________

Phone #______________________________ Fax#______________________________

Funding Contact Name:____

Phone# ____________________ FAX ______________ Email____________________

Scheduling Contact Name: ____

Phone# ____________________ FAX______________ Email____________________

Case/Home Manager Name: ____

Phone# ____________________ FAX______________ Email____________________

Name of person for Emergency Contact:

__________________________ Phone#______________ Email____________________

Late Charges

It is the responsibility of the Parent, Guardian, or Living Support Center to assure The Dental Anesthesia Center of complete and prompt payment of services rendered. Refusal to do so may result in collection process. A billing charge of $10.00 will be assessed each month on accounts over 60 days. Responsible party agrees to pay collection costs and reasonable attorney fees incurred to collect any outstanding balance.

X____ Date__________________

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?	☐	☐

If yes, what condition is being treated? ______________________

	Yes	No
Are you taking any medications?	☐	☐

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?	☐	☐

If yes, please explain. ______________________

	Yes	No
Do you have dental phobia or anxiety?	☐	☐
Do you have gag reflex?	☐	☐
Do you or your family members have a history of anesthesia problems?	☐	☐

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?	☐	☐

If yes, please list. ______________________

	Yes	No
Are you taking or have you ever taken medications for osteoporosis, bone disease, bone cancer including Bisphosphonates?	☐	☐

Date Treatment began __________

	Yes	No
Do you use recreational drugs?	☐	☐

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?	☐	☐

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

	Yes	No
Do you drink alcoholic beverages?	☐	☐

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? __________

WOMEN ONLY Are you:

	Yes	No
Pregnant?	☐	☐

Number of weeks ______________________

	Yes	No
Taking birth control pills or hormone replacement?	☐	☐
Nursing?	☐	☐

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	☐	☐

	Yes	No
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: ______		

	Yes	No
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: ______		

	Yes	No
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: ______

Michael J. Hoffmann, DDS 314-560-2858
Maris E. Behl, DDS 417-818-0068
Sean M. Thoms, DMD, MS 314-448-5972
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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