THE DENTAL
ANESTHESIA CENTER

950 Francis Place, Suite 305
St. Louis, Missouri 63105
(314) 862-7844
Fax: (314) 862-4504
www.dentalsleepstlouis.com

Welcome to The Dental Anesthesia Center!

REGISTRATION:

Please complete the enclosed forms **PRIOR** to the first visit and bring them with you. We need information regarding the patient's medical diagnosis, medical history, allergies and sensitivity to anesthetics. **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, guardianship if applicable, person responsible for payment, their address and contact info, and HIPAA release.

If you have dental **insurance** benefits, **please contact your insurance company prior to your appointment to determine if you can go outside of your network.** Most PPO Plans allow out of network benefits. We are happy to assist you with the submittal of your dental claims.
We require your insurance card and drivers license. Estimated co-pay is required at time of service with any remaining balance due upon final Insurance payment. We accept cash, check, Visa, Mastercard, Discover, American Express and Carecredit.

If you have any current x-rays (taken within the last 3 years) **contact your dentist and request to have the x-rays emailed to secure@dac950.com at least 48 hours prior to your appointment date.**

Upon conclusion of the comprehensive exam, we will discuss the initial findings and propose a treatment plan. if unable to cooperate, the findings of the initial examination may be limited so there could be unexpected changes during the course of treatment. We will provide an estimate of the proposed treatment recommendations and will discuss the financial requirements.

Due to the extended wait to obtain an appointment, we **require a 24 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, your appointment may not be reserved.**

Feel free to contact us if you have any questions. We may be reached at 314-862-7844. We look forward to meeting you!!

MICHAEL J. HOFFMANN, DDS, FADSA • MARIS E. BEHL, DDS • SEAN M. THOMS, DMD, MS
Diplomate American Dental Board of Anesthesiology

Insurance and Payment Information

Welcome to the Dental Anesthesia Center. We welcome any questions you may have about billing procedures, dental insurance and payment arrangements.

Dental insurance is a benefit provided to you, as arranged by your employer. Please contact your carrier to determine if you may seek care outside of your dental insurance network.

Once the treatment plan has been determined, we will provide the courtesy of submitting your dental expenses to your dental insurance. You must provide your insurance card and a source of personal identification. If your insurance agrees to assign the benefits directly to us, we will contact the insurance carrier for an estimate of the copay you are personally responsible for. This ESTIMATED copay is due at the time services are rendered. (the portion not covered by your insurance). When your dental insurance finalizes your dental claim, any portion above or over what we have estimated is due at that time or will be refunded to you.

If you are a patient without the benefit of dental insurance, payment for services will be due on the day services are completed (we do accept Visa, MasterCard, American Express and Discover). For account balances over $300.00 we can provide extended payment plans through CARECREDIT and LENDING CLUB. There is a 6 month interest free plan available, as well as extended 2, 3, 4 and 5 year payment plans at an interest rate
determined by your credit history.

Charges for the first visit are due at the time of services.

Please let us know if you have any questions, (314) 862-7844.

Thank you,

Cheri Williams

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.

THE DENTAL
ANESTHESIA CENTER

Welcome!
Whom may we thank for referring you?

_____ Date _____

❑ Adult Patient ❑ Child/Adolescent Patient ❑ Special Needs (lives with patents/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 special needs dependents)

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

Birth Mother _____ Cell# _____ Wk# _____

Address _____City _____ ST _____ ZIP _____ Email _____

Birth Father _____ Cell# _____ Wk# _____

Address _____City _____ ST _____ ZIP _____ 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 though I, the undersigned, signed each claim. Furthermore, I authorize direct assignment of benefits fo 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 Employee (Subscriber Name) _____ Birthdate _____

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

Secondary DENTAL Insurance Co. Name: _____ Phone _____

Secondary DENTAL Insurance Co. Address: _____

Secondary Employer (Group name) _____

Secondary Employee (Subscriber Name) _____ Birthdate _____

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 pail?	☐	☐

	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? _____

_____

_____

~~Please provide a separate list of Medications.~~

_____

Physician Name _____

Date of last physical exam _____

Physician Phone _____ Fax _____

Pharmacy Phone _____

_____

	Yes	No
Have you had a serious illness, operation or hospitalization in your lifetime?	☐	☐

If yes, what condition is being treated? _____

_____

_____

	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?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

Date: _____ If yes, have you had any complications? _____

Are you taking or have you ever taken medications for osteoporosis, bone disease, bone cancer including Bisphosphanates?	☐	☐

Date Treatment began _____

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

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:

Pregnant?	☐	☐

Number of weeks _____

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	☐	☐

	Yes	No
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	☐	☐

	Yes	No
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date:_____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐
Covid	☐	☐
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	☐	☐
Easting 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	☐	☐
If yes, 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, specify: _____		

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 information for treating me. I acknowledge that my questions, if any, about inquires 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
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Patient Name: _____ **Date:** _____

Expires in 1 year

Acknowledgement — 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 concerning 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

Acknowledgement 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**

THE DENTAL
ANESTHESIA CENTER
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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