THE DENTAL
ANESTHESIA CENTER

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 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? _____

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

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

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	☐	☐
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
ANESTHESIA CENTER

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