



950 Francis Place • Suite 305 • Clayton, MO 63105
(314) 862-7844 • www.dentalsleepstlouis.com

Registration

Welcome to The Dental Anesthesia Center!

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 medications** including over the counter. These forms are important to determine the course of treatment.

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 driver's license. Estimated co-pay is required at time of service with any remaining balance due upon final insurance payment. We accept cash, check, all major credit cards, CareCredit and Cherry.

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 day.**

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 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 48-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!



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Welcome!

Whom may we thank for referring you?

Name _____ 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/Phone _____

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? ☐ Married ☐ Mother ☐ Father ☐ Joint ☐ Other

Mother _____ Birthdate _____ Cell # _____ SSN _____

Address _____ City _____ ST _____ Zip _____ Email _____

Father _____ Birthdate _____ Cell # _____ SSN _____

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 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) _____ Birthdate _____

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) _____ Birthdate _____

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

Emergency Contact _____ Relation _____ Phone _____

Delinquent accounts over 60 days are subject to a \$10 late fee. If the balance remains unpaid, the account may be referred to a collection agency. The patient is responsible for all costs of collection, including collection agency fees, attorney fees, and associated recovery costs. 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 _____

Michael J. Hoffmann, DDS, FADSA
Diplomate American Dental Board of Anesthesiology
After Hour Emergency Only (314) 560-2858

Maris E. Behl, DDS
After Hour Emergency Only (417) 818-0068

Sean M. Thoms, DMD, MS
Diplomate American Dental Board of Anesthesiology
After Hour Emergency Only (314) 448-5972



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Health History

Name _____

Birthdate _____ Weight _____

Height _____ BMI _____

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's name _____

MEDICAL INFORMATION

	Yes	No
Are you currently under the care of a physician/specialist? . . .	☐	☐
If yes, what condition is being treated? _____		
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 _____		

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 _____		

RELEVANT INFORMATION

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 _____		
Are you taking or have you ever taken medications for osteoporosis, bone disease, bone cancer including Bisphosphonates?	☐	☐
Date treatment began _____		
Do you currently use recreational drugs?	☐	☐
Have you used recreational drugs in the past?	☐	☐
If yes, please 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 anything in the following list? To all YES responses, specify type of reaction.

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

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

	Yes	No		Yes	No		Yes	No
Artificial (prosthetic) heart valve	☐	☐	Bronchitis	☐	☐	Mental health disorders ..	☐	☐
Previous infective endocarditis	☐	☐	Emphysema	☐	☐	Specify		
Damaged valves in transplanted heart	☐	☐	Sinus trouble	☐	☐			
Congenital heart disease (CHD)	☐	☐	Tuberculosis	☐	☐			
Unrepaired, cyanotic CHD	☐	☐	Cancer/Chemotherapy/ Radiation treatment	☐	☐			
Repaired (completely) in last 6 months	☐	☐	Chest pain upon exertion	☐	☐	Neurological or genetic disorders	☐	☐
Repaired CHD with residual defects	☐	☐	Chronic pain	☐	☐	If yes, specify		
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>			Diabetes Type I or II	☐	☐			
	Yes	No	Eating disorder	☐	☐			
Cardiovascular disease	☐	☐	Malnutrition	☐	☐			
Angina	☐	☐	Gastrointestinal disease ...	☐	☐	Recurrent infections	☐	☐
Arteriosclerosis	☐	☐	G.E. Reflux/persistent heartburn	☐	☐	Type of infection		
Congestive heart failure ..	☐	☐	Ulcers (stomach)	☐	☐	Kidney problems	☐	☐
Damaged heart valves ...	☐	☐	Thyroid problems	☐	☐	Excessive urination	☐	☐
Heart attack	☐	☐	Stroke	☐	☐	Night sweats	☐	☐
Heart murmur	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐
Low blood pressure	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Persistent swollen glands in neck	☐	☐
High blood pressure	☐	☐	Epilepsy	☐	☐	Severe headaches/ migraines	☐	☐
Other congenital heart defects	☐	☐	Fainting spells or seizures	☐	☐	Severe or rapid weight loss	☐	☐
Mitral valve prolapse	☐	☐	Sleep disorder/sleep apnea	☐	☐	Sexually transmitted disease	☐	☐
Pacemaker	☐	☐	If yes, specify			If yes, please specify type		
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
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Name of physician or dentist making recommendation		
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 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 _____

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Sleep Apnea Risk Questionnaire

Name _____

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.

- 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



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ACKNOWLEDGMENT- RECEIPT

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.

Patient Name _____ Date _____

Expires in 1 Year

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

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 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 required.

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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