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

SPECIAL NEEDS / DISABLED PATIENTS

Registration

Welcome to The Dental Anesthesia Center!

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 **patient's 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 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, the appointment may not be reserved.**

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

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
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Welcome!

Whom may we thank for referring you?

Name _____ 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 accompanying 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

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.

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 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 _____

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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
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, 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 _____		

	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 _____ Phone _____

	Yes	No
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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