SINDELAR DENTAL

Sindelar Dental Group
11225 Tesson Ferry Rd, Saint Louis, MO 63123

Patient Information

Patient Name: _____ Date: _____
Male____ Female_____ Married___ Single___ Child___ Other___
Social Security #_____ Birth Date_____ E-mail_____
Home Phone_____ Work Phone_____ Cell Phone_____
Address_____
Street City State Zip

Responsible Party Information

Name_____ _____
Male___ Female___ Date of Birth_____ E-mail_____
Address_____
Street City State Zip
Home phone_____ Work Phone_____ Cell Phone_____

Employment Information

The following is for ____ The Patient _____ The Person Responsible for payment
Employer Name_____ Occupation_____
Address_____
Street City State Zip

Referral Information

Whom may we thank for referring you to our practice? _____Another patient, friend, relative
_____Insurance Plan _____Yellow Pages _____Radio _____ School _____Work _____ other
Name of Person or Office referring you to our practice_____

Insurance Information

Primary
Name of Insured _____ Is Insured the patient? ____Yes ____ No
Insured's Birth Date_____ ID#_____ Group # _____
Insured's Employer Name_____
Patient's relationship to Insured ____Self ____ Spouse ____ Child ____ Other _____
Insurance Plan Name _____ Phone _____
Address _____
Street City State Zip

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Secondary

Name of Insured _____ Is Insured the patient? ___Yes ___No
Insured's Birth Date _____ ID#_____ Group # _____
Insured's Employer Name _____
Patient's relationship to Insured ____Self ____ Spouse ____ Child _____ Other_____
Insurance Plan Name _____ Phone _____
Address_____
Street City State Zip

Health Information

Date of Last Dental Visit _____ Reason for this Visit _____

- Have you ever had any complications following dental treatment? _____No _____ Yes
  If yes, please explain_____
- Have you been admitted to a hospital or needed emergency care during the past two years?
  __ No __ Yes If yes, please explain _____
- Have you recently undergone surgery? ___No ___Yes
  If yes, please explain_____
- Are you under the care of a physician? ___No ___ Yes
  If yes, please explain _____
- Do you have any health problems that need further clarification? ____No ___ Yes
  If yes, please explain _____

Name of Physician_____ Phone _____

Please list all Medication_____
Please list all Allergies_____
Do you take Pre Medications for Dental Procedures? _____

Have you ever had any of the following? Please check all that apply:

__HIV/AIDS
__Anemia
__Arthritis
__Artificial Joints
__ Asthma
__ Blood Disease
__ Cancer
__ Diabetes
__ Dizziness
__ Epilepsy
__ Excessive Bleeding
__ Fainting
__ Glaucoma
__ Growths
__ Hay Fever
__ Head Injuries
__ Heart Disease
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ Jaundice
__ Liver Disease
__ Mental Disorders
__ Nervous Disorders
__ Pacemaker
__Pregnant
due Date_____
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Rheumatism
__ Sinus Problems
__ Stomach Problems
__ Kidney Disease
__ Stroke
__ Tuberculosis
__ Tumors
__ Ulcers
__ Venereal Disease
__ Codeine Allergy
__ Latex Allergy
__ Penicillin Allergy
__ Eating disorders

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Have you ever had any of the following? Please check those that apply:

Teeth:
Please check all that apply:

__ Broken, sharp or fractured teeth
__ Broken fillings
__ Cavities
__ Areas collecting food
__ Sensitive teeth
__Hot __Cold
__Toothache keeping you up at night

Gums:

__ Bleeding gums
__ Bad Breath
__ Recessions
__Loose teeth
__ Family history of gum disease
__ Have you ever had Gum Therapy?
If yes, Date_____

Jaw/Bite/Headaches:
Please check all that apply:

__Jaw joint noise or clicking
__ Pain in the jaw, face, or neck
__ Headaches
__ Ear pain
__ Worn or sharp teeth

Sinus:

Do you ever experience:

__ Sinus Headaches
__ Stuffy Nose
__ Earaches
__ Chest Congestion
__ Fever
__ Drainage

Have you been seen by:

__ Allergist
__ ENT
__ Primary Care Physician
__ Neurologist
__ Sleep Specialist
__ Other

Sleep:
Please check all that apply:

__ Snoring
__ Wake up with dry mouth
__ Daytime sleepiness
__Waking frequently throughout the night
__ Bed partner notices interruptions in breathing during sleep
__ Diagnosed with Sleep Apnea __ Use CPAP
Have you ever taken a sleep test? ___ No ___ Yes If yes, Date _____

Nutrition and Lifestyle:
Please check all that apply:

__ Past or current dietary supplement use
__ Consumption of carbonated/sweetened beverages
__ Regular use of gum, coughs drops, or breathes mints
Have you ever been tested for antioxidant levels as part of a cancer prevention screening?
____ No ____ Yes

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Consent for Services

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are preformed.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge will be applied to any unpaid balance on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- I understand that the fee estimate listed for the dental care can only be extended for a period of six months from the date of the patient examination.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the said Doctor, or his assignee, at the time said services are rendered, or with five days of billing if credit shall by extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content

_____Date _____ Relationship to Patient _____
Signature of Patient, parent or guardian

_____ Date _____ Relationship to Patient _____
Signature of guarantor of payment/responsible party