KELLERMAN DENTAL
Advanced Dentistry

Date: _____

Patient Information

Last	First	Date of Birth:	Age: Sex: M F
Home Phone ( )	Cell Phone ( )		Work Phone ( )
Address:		City:	State: Zip:
Social Security Number:			
Emergency Contact:		Relationship:	Contact Number: ( )
Email Address:		Occupation:	
How did you hear about our office?		Reason for this Visit:	

**If a patient is a minor (under 18), they need to be accompanied to all visits by parent/guardian or a designated adult. Failure to follow this will prevent the minor from being seen for their appointment.*

Responsible Party Name (If under 18 Parent or Guardian Name)		**Or Circle: Same as Above**
Last:	First:	Relationship to Patient:
Date of Birth:	Home Phone: ( )	Alternate Phone: ( )
Social Security Number:		Employer:

Please circle all services you're interested in:
Invisalign
Bridge/ Crowns/Implants/Tooth Replacement
Restoring Worn or Broken Teeth
Cleanings/ Healthy Gums
TMJ/ Jaw pain/ Grinding/ Clenching
Whitening/ Veneers/ Smile Makeover
Sleep Apnea Treatment
Sedation Dentistry

Please list any other concerns/ requests you would like to share:

HIPAA Consent

Authorization to release medical information to other individuals

Date: _____
Patient's Date of Birth: _____
Patient's Name: _____

I hereby authorize Kellerman Dental to release my Protected Health Information either verbally or in printed form to the following persons:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

_____

Patient/ Guardian Signature **Date Signed**

☐ I authorize Kellerman Dental to release the Protected Health Information to anyone that may bring the patient in for their visit whom may not be listed above.

☐ I authorize the release of my personal medical information to any doctor whom I may be referred to.

Acknowledgment of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Patient's Printed Name)

_____

Patient/ Guardian Signature **Date Signed**

Authorization and Release

I hereby grant Kellerman Dental permission to use diagnostic photographs and records in publications and/or on the office website, blog, Facebook and You Tube for informational or marketing reasons. I understand that I have the right to request, in writing, removal of the photo and/or video from the website within 30 working days of receipt of the request by Kellerman Dental. I understand that this photo and/or video may be used in office publications or on a website designed to promote dental services as well as offer information and resources. By signing below, I acknowledge my understanding of the above and grant my permission for use of the photograph(s) and/or video(s). ☐ I choose to not release any photograph(s) or video(s) at this time

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I understand that providing incorrect information can be dangerous to my health. I authorize my dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Patient/ Guardian Signature **Date Signed**

Kellerman Dental Financial Responsibility Form

Patient's Name: _____ Date of Birth: ____/_____/_____
If patient is under the age of 18, name of individual who is financially responsible for
Patient: _____ Telephone #_____-_____-_____

If you have dental insurance, we will file the claims for you, as a complimentary service. Your complete insurance information must be presented at the time services are provided. If this information changes, it is the patient's responsibility to update Kellerman Dental. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage of payments to Kellerman Dental. We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

We will provide you with a verbal and written estimate of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates given to us by your insurance company and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company which could result in an account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. For your convenience, you may keep a credit card on file to process any balance not covered by your insurance or to process any remaining balance not paid within 30 days after insurance payment is received. This card will also be used to reimburse you if there is a credit after insurance has paid. If no card is kept on file, we simply ask for payment in full the day of services.

To make payment for your care more convenient, we have several payment options. We accept:

Cash, Check, Visa, MasterCard

**For patients who would like to make low monthly payments, CareCredit patient payment plans are available.

All procedures are paid for at time of service. Any treatment scheduled in excess of one hour requires a 50% pre-payment of the estimated treatment cost to reserve doctor's time.

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are incurred by our office.

For your convenience, if you would like to leave a card on file for your account, please provide the details below:

Card Type:_____ Card Number:_____
Exp. Date:_____
Name on Credit Card:_____
Signature:_____

We ask that you realize we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we prescribe and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.

If a payment has not been received on the account in 90 days, the account will be sent to collections and additional fees will be applied to any unpaid balances.

We request a 48-hour cancellation notice for scheduled appointments. A cancellation fee of $30 will be charged for hygiene and $50 for doctor if a 48-hour notice is not provided.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

_____

Patient/ Guardian Signature Date Signed

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex _____
   - ☐ nuts _____
   - ☐ fruit _____
   - ☐ other _____
3. heart problems, or cardiac stent within the last six months _____ ☐ ☐
4. history of infective endocarditis _____ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐
6. pacemaker or implantable defibrillator _____ ☐ ☐
7. orthopedic implant (joint replacement) _____ ☐ ☐
8. rheumatic or scarlet fever _____ ☐ ☐
9. high or low blood pressure _____ ☐ ☐
10. a stroke (taking blood thinners) _____ ☐ ☐
11. anemia or other blood disorder _____ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____ ☐ ☐
15. asthma _____ ☐ ☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)___ ☐ ☐
17. kidney disease _____ ☐ ☐
18. liver disease _____ ☐ ☐
19. jaundice _____ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency _____ ☐ ☐
21. hormone deficiency _____ ☐ ☐
22. high cholesterol or taking statin drugs _____ ☐ ☐
23. diabetes (HbA1c = _____) _____ ☐ ☐
24. stomach or duodenal ulcer _____ ☐ ☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____ ☐ ☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates)_____ ☐ ☐
27. arthritis _____ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)_____ ☐ ☐
29. glaucoma _____ ☐ ☐
30. contact lenses _____ ☐ ☐
31. head or neck injuries _____ ☐ ☐
32. epilepsy, convulsions (seizures) _____ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) _____ ☐ ☐
34. viral infections and cold sores _____ ☐ ☐
35. any lumps or swelling in the mouth _____ ☐ ☐
36. hives, skin rash, hay fever _____ ☐ ☐
37. STI/STD/HPV _____ ☐ ☐
38. hepatitis (type ____) _____ ☐ ☐
39. HIV/AIDS _____ ☐ ☐
40. tumor, abnormal growth _____ ☐ ☐
41. radiation therapy _____ ☐ ☐
42. chemotherapy, immunosuppressive medication _____ ☐ ☐
43. emotional difficulties _____ ☐ ☐
44. psychiatric treatment _____ ☐ ☐
45. antidepressant medication _____ ☐ ☐
46. alcohol/recreational drug use _____ ☐ ☐

ARE YOU:

47. presently being treated for any other illness _____ ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)_____ ☐ ☐
49. taking medication for weight management _____ ☐ ☐
50. taking dietary supplements _____ ☐ ☐
51. often exhausted or fatigued _____ ☐ ☐
52. experiencing frequent headaches _____ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco _____ ☐ ☐
54. considered a touchy/sensitive person _____ ☐ ☐
55. often unhappy or depressed _____ ☐ ☐
56. taking birth control pills _____ ☐ ☐
57. currently pregnant _____ ☐ ☐
58. diagnosed with a prostate disorder _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

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Name: _____

Date: _____

Age: _____ Sex: ☐ Male ☐ Female

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of dozing**
Sitting and reading……....	_____
Watching TV……....	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)……	_____
As a passenger in a car for an hour without a break……	_____
Lying down to rest in the afternoon when circumstances permit……	_____
Sitting and talking to someone……	_____
Sitting quietly after a lunch without alcohol…….....	_____
In a car, while stopped for a few minutes in traffic…….....	_____
TOTAL……..	_____

SCORE:

0-10	Normal range
10-12	Borderline
11-12	Mild excessive daytime sleepiness
13-15	Moderate excessive daytime sleepiness
16-24	Severe excessive daytime sleepiness
12-24	Abnormal excessive daytime sleepiness

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STOP BANG Questionnaire

1.) **Snoring** — Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
YES NO

2.) **Tired** — Do you often feel tired, fatigued, or sleepy during daytime?
YES NO

3.) **Observed** — Has anyone observed you stop breathing during your sleep?
YES NO

4.) **Pressure** — Do you have or are you being treated for high blood pressure?
YES NO

5.) **BMI** — By referring to the chart on the back of this page, is your BMI anything over healthy?
YES NO

6.) **Age** — Age over 50 years old?
YES NO

7.) **Neck** — Neck circumference greater than 15.7inches? (Size 16 shirt)
YES NO

8.) **Gender** — Are you male?
YES NO

3 or more YES = Risk of OSA – Sleep study recommended
Less than 3 YES = Low risk of OSA

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.*

KD
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What is the Kellerman Dental Difference?

The most common words we hear from our new patients after their visit are, “This is different than any dental visit I have ever had before.” For us, there is no better compliment than that! When you visit Kellerman Dental, here are a few things you can expect, on your first visit and for every visit after that:

- To be greeted warmly and to find a team of providers genuinely interested in assisting you achieve your dental goals in a relaxing and pleasant environment.
- To always feel supported, to never feel judged, no matter what your dental condition.
- To have anxiety-reducing services available from neck pillows, warm blankets, Netflix, headphones and sedation dentistry.
- To have confidence that you are receiving care from a dentist frequently named one of the Top Dentists in St. Louis, by both peers and patients; A dentist who has completed numerous advanced programs in cosmetic, restorative, and bio rejuvenation dentistry.
- To encounter a team with the shared philosophy that all treatment should be determined by the best interest of the patient, not for the benefit of an insurance company.
- To know your treatment and care is customized exclusively for you!
- To feel confident that you are supported by a team of professionals who will go the extra mile to ensure you receive the dentistry you desire and make the process enjoyable and stress-free.

KD
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What We Believe All Patients Deserve…

1. To be given a full dental assessment and treatment options, both when new to the practice, and periodically thereafter, so each patient may achieve the level of dental health and aesthetics they desire.

2. To be treated with the respect and dignity in a guilt free environment, especially related to any dental health issues the patient is now experiencing.

3. To have all treatment completed in a comfortable manner.

4. To do our best to honor and respect your time.

5. To have all treatment completed on time in the least amount of appointments possible.

6. To have access to the best materials, laboratories, technology, and techniques available in dentistry today.

7. For all treatment to be driven and guided for the benefit of the patients, not for the benefit of the insurance company. The dental office will file all paperwork and do our best to explain all dental benefits to patient.

8. To receive multiple payment options as well as long-term payment plans and for all costs of treatment to be fully explained and in writing.

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Your Commitment to Your Dental Health

Achieving optimum oral health takes a commitment from you as well as from us. This relationship involves teamwork. Just as we place high standards on ourselves, we ask the same from our patients.

Our Expecations of You, Our Patient;

Communication- We want to know how you feel about all aspects of your experience with us. We will develop a Personalized Dental Plan for you and expect you to tell us honestly about your thoughts and feelings. We are here to serve you and want you to be comfortable in making decisions concerning your appearance and your dental health.

Time- We stand alone in the medical/dental community by truly focusing on our patients oral health goals. While we understand that emergencies do arise, we choose not to work with patients who have missed three appointments in our office. Reserving time in our office is a privilege you will want to guard.

Finances/Cost- From the moment you step inside, you'll notice our office is different. Please don't be surprised to discover our fees are not the lowest in our area. We could not offer the level of technology and service we do otherwise. Because of this, we have designed payment arrangements that are comfortable and convenient, so cost is rarely a concern. You will receive value; this is our commitment at Kellerman Dental. For our patients with dental insurance coverage- we will be happy to accept your insurance as a form of payment. We have found far too often insurance companies do not have your best dental health in mind and it is for this reason that we do not let them dictate our relationship with you.

Referrals- We enjoy working with patients just like you! We ask that whenever you have the opportunity to mention our name to your family and friends that you please do so. Please know that we will do our absolute best to provide them with the same level of dentistry that's truly beyond exceptional. We especially enjoy treating patients that are referred by our existing patients. There's no better validation of a happy client than hearing that same great news from one of the friends they recommend!

Following these guidelines will ensure a long lasting relationship between us! We want to look forward to a wonderful relationship built in trust, credibility, and great dental solutions.