Patient/Guardian Instructions

Please complete the following **Anesthesia Patient Information/Medical History** form**.** **Submit** completed forms to your dental office at least two weeks prior to your appointment.

Read and carefully follow the **Pre-Anesthesia Instructions**.

Also review and keep the **Financial Policy** and **Post-Anesthesia Instructions**.

We are not in network with insurance and do not file a claim on your behalf.

Read the **Anesthesia Consent form** and sign. Anesthesia services in dentistry have proven to be very safe and predictable, however we want to inform you of possible risks and side-effects. Your provider will discuss any questions with you before treatment is performed.

Your provider will also attempt to call or text you the evening before your appointment to explain what to expect during your visit. Please list a contact number where you can be available for that call or text.

If you have questions that you would like to discuss before your appointment date, please feel free to call us at 512-909-3171

3401 Royal Vista Blvd, Ste A100, Round Rock, TX. 78681
Phone: 512-909-3171 Fax: 512-246-3678
www.iheartsedation.com

SedaDent
ANESTHESIA

Anesthesia Patient Information

Patient Name________________________________ Date of Birth____/____/_______ Height__________ Weight_________

Street Address____________________________________City___________________________ State_____ Zip____________

Mobile (   ) _____-_______ Alternate (   ) _____-_______ Email ____

Responsible Party's Name _______________________________________Relationship to Patient ____________________________

Dental Insurance Carrier: ________________________ Subscriber ID:___________________ Group Number: _____________

Health Insurance Carrier: ________________________ Subscriber ID:___________________ Group Number: _____________

Insurance Policy Holder Name: ________________________________ Policy Holder Date of Birth: _______________

Medical History

List all patient medications: ____

1. Do you have any allergies or reactions to medications, food or latex? Yes No
   If yes, explain ____
2. Do you have any congenital disability or syndrome such as trisomy 21 (Down syndrome)? Yes No
   If yes, explain____
3. Do you have any heart problems such as congenital defects, murmurs, high blood pressure or shortness of breath? If yes, explain____ Yes No
4. Do you have any lung problems such as asthma, bronchitis, recent cold or flu, RSV or tuberculosis? Yes No
   If yes, explain____
5. Do you have any stomach or abdominal problems such as reflux, nausea or difficulty swallowing? Yes No
   If yes, explain____
6. Do you have any endocrine problems such as diabetes, thyroid problems, pancreas or other? Yes No
   If yes, explain____
7. Do you have any muscular problems such as weakness, paralysis, spasticity, muscular dystrophy? Yes No
   If yes, explain____
8. Do you have neurologic problems such as seizures, palsy, developmental delay, stroke, autism, ADHD? If yes, explain____ Yes No
9. Do you have any kidney problems such as kidney failure?
   If yes, explain____ Yes No
10. Do you have any blood problems such as hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV or transfusions? If yes, explain____ Yes No
11. Has your child or any blood relatives ever had problems with general anesthesia? Yes No
    If yes, explain____
12. Please list all serious illnesses or hospitalizations and dates:
    ____
13. Please list all surgical operations and dates:
    ____

I understand that the accuracy of this health history is critical to the safety of general anesthesia. I have carefully answered all questions truthfully and to the best of my knowledge. **Please use the back of this form if more room is needed to complete the health history**.

Signature of Responsible Party____ Date______________

For Dental Office Staff Use Only

Procedure Information

Dental Office Name : ____________________________ Treating Dentist:___________________________________

Date of Service: ________________________________ Length of Treatment: _____________________________

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The Health Insurance Portability and Accountability Act (HIPAA)

Patient Name____ Date of Birth____________________________

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Administrative Simplification portion of HIPAA required the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

The *Sedadent Anesthesia Services Notice of Privacy Practices* describes Sedadent Anesthesia Services policies in regard to HIPAA. This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully and sign below.

Yes, I've read Sedadent Anesthesia Services' Notice of Privacy Practices

Signature of Patient or Parent/Guardian____

Print Name____

Date ____________________________________

SedaDent
ANESTHESIA

PRE - ANESTHESIA INSTRUCTIONS

Drinking and Eating: In order to decrease the risk of complications during anesthesia, it is VERY IMPORTANT that your child does NOT have ANYTHING TO EAT eight (8) hours before your scheduled dental procedure. During anesthesia the muscles above the stomach can relax, releasing stomach contents into the lungs. This can lead to serious complications including death. You may have CLEAR LIQUIDS ONLY, up to two (2) hours before the procedure. Examples of clear liquids include water, apple juice, or Gatorade. Patients consuming food, milk, orange juice or other non-clear liquids within eight (8) hours will be rescheduled.

Clothing: Loose clothing with short sleeves is desirable, as are two-piece outfits, to allow easy monitor placement. Contact lenses must be removed before the appointment. Do not wear fingernail polish the day of appointment. For children, a change of clothing is recommended for unexpected urination. Please use the restroom upon arrival at the dental office.

Change in Health: Please inform the doctor of any change in your child's health prior to your appointment. The development of a cold or fever can increase the risks of anesthesia. Sick patients may be reappointed for safety reasons.

Medication: Please follow your regular schedule of medications unless otherwise directed by the doctor. Medications may be taken with only a small sip of water.

Accompanied by an adult: A responsible adult must accompany all anesthesia patients to and from the appointment. The responsible adult should remain in the office during the appointment unless otherwise authorized by the practitioner. A responsible adult must drive the patient home. (Buses or cabs are unacceptable)

Questions or Concerns: Please expect a call from the doctor the night before the appointment to answer any questions or concerns.

Please contact Sedadent Anesthesia Services if you have any other questions or concerns: **(512) 909-3171**

SedaDent
ANESTHESIA

POST - ANESTHESIA INSTRUCTIONS

Patient: ______________________________

Date/Time: ____________________________

Dentist: ________________________________ phone: ___________________________

Anesthesiologist: _________________________ phone: ___________________________

Activity: Patient may feel sleepy for several hours and may nap off and on throughout the day. Patient should not drive, ride a bike, swim, jump on trampolines, sign contracts, or do any other activity that requires his/her full coordination for at least the remainder of the day. Patient can usually expect to resume normal activities on the day following surgery.

Fever: Patient may become flushed with a slight fever following the anesthesia. Patient should be kept indoors in a cool place for the remainder of the day.

Diet: Begin slowly with mild, clear liquids (water, Gatorade, soda). Slowly introduce more solid foods throughout the day. Avoid meat or dairy for 2-3 hours. The dentist may have additional dietary restrictions depending on the patient's dental procedure.

Intravenous Site (IV): A small percentage of patients experience post-operative tenderness and/or redness at the IV site. Bruising is common and expected but swelling/increasing redness is not normal.

Sore Throat: A breathing tube is normally placed through the right or left side of the nose. If you notice redness or small amounts of blood when patient blows his or her nose, this is normal. The patient may also have a sore throat as a result of the breathing tube for up to three days following surgery.

Pain/Discomfort: It is not uncommon for the patient to experience some discomfort or pain following the dental procedure. The anesthesiologist may have administered IV pain medications during the surgery, but these generally wear off within a few hours after the procedure. The dentist may have administered local anesthesia ("lidocaine") so the patient may be numb in parts of the mouth. If pain persists despite taking the recommended pain medications, please contact the **dentist.**

The following medications are recommended as needed for post-operative pain control:

Tylenol / Acetaminophen (as needed, dose per package instructions)
May begin immediately. may begin at ________ pm / am

AND/OR

Motrin / Advil / Ibuprofen (as needed, does per package instructions)
May begin at _________pm / am

AND/OR

Pain medication prescribed by dentist. Take as directed
Other: ____________________________________

Nausea/Vomiting: Nausea and vomiting occasionally occur following anesthesia. If the patient becomes nauseated or vomits following discharge, restrict to clear liquids until the nausea passes. If vomiting persists beyond 4 hours, contact the **anesthesiologist**.

Bleeding: Follow the dentist's instruction regarding post-operative bleeding. If bleeding persists longer than you were told to expect or seems excessive contact the **dentist.**

I have reviewed these discharge instructions with my anesthesiologist or his/her assistant and have had all of my questions answered to my satisfaction. I will receive a copy of these instructions.

Discharged to (Print Name)____________________________________ Relationship ______________________________

Signature____

Patient name:______________________________DOB ____________________

DISCLOSURE AND CONSENT - ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.*

I voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

I understand that anesthesia/analgesia involves additional risks and hazards but I request the use of anesthetics/analgesia for the relief and protection from pain or anxiety during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐ _____GENERAL ANESTHESIA – injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

☐ _____REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

☐ _____SPINAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____EPIDURAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____DEEP SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ _____MODERATE SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Additional comments/risks:

☐ _____PRENATAL/EARLY CHILDHOOD ANESTHESIA - potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

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I understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent.

This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

____

DATE: ______________________ **TIME:** ____________________ **A.M. /P.M.**

WITNESS:

____
Signature

____
Name (Print)

____
Address (Street or P.O. Box)

____
City, State, Zip