Pre-Operative Anesthesia Instructions

Please read and follow carefully the instructions below.

1. **Eating and Drinking:** Do Not take in any **solid food or milk for 8 hours** before the time of your dental appointment. Up until **3 hours** before the time of your dental appointment, you may continue to drink ONLY water.

   Starting 2 hours before your dental appointment, **STOP ALL** liquids. This includes NO juice, chewing gum, smoothies, or sucking on hard candy.

2. **Transportation:** You must arrange to have a responsible adult companion physically present in the dental office at the time of discharge to escort you home. Patients under age eighteen must have a parent or legal guardian present at the time of surgery in order to give written consent for anesthesia.

   Parents: If you are driving your child home, there MUST be another adult in the car to take care of the child.

3. **Medications:** Bring a list of all medicines you are now taking. Include with this list the doses, how often, and when you take the medications.

   If you have recently taken any illegal drugs, you must tell the anesthesiologist. Certain drugs can react adversely with the medications that the doctor may be using.

4. **Clothing:** You should be dressed in a loose fitting outfit with a short-sleeved shirt. This will allow the anesthesiologist to start an IV and place all monitors without the need to remove any clothing. Please bring a blanket, as patients tend to become cold while under anesthesia. Contact lenses must not be worn to the office.

5. If you start to develop or have a cold, fever, or any other acute illness, call your dentist's office.

6. Pregnant women cannot receive anesthesia for non-emergency surgery.

7. Patients can NOT attend school or daycare on the day of surgery

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Pediatric Health History

Patient Name: _____ Parent: _____

Mailing Address: _____ City: _____

Zip Code: _____ Telephone: _____

Patient Medical History

Gender: M F Weight: _____ lbs Height: _____

Date of Birth: _____

PLEASE CHECK:

o yes o no Are you ALLERGIC to anything? Name medications and type of reactions:

_____

o yes o no Are you taking any MEDICATIONS? (Include prescription, over the counter, eye drops, INHALERS, and herbal medications):

_____

o yes o no Please list any previous surgeries: _____

o yes o no Have you ever had problems with anesthetics (nausea or vomiting)?

o yes o no Family history of Malignant Hyperthermia?

o yes o no Have you had a recent Upper Respiratory Tract Infection? When?

_____

Has the patient ever had or been diagnosed with:

o yes	o no	Asthma	o yes	o no	Hemophilia
o yes	o no	Bronchitis	o yes	o no	Cystic Fibrosis
o yes	o no	Sleep Apnea	o yes	o no	Hernia
o yes	o no	Cerebral Palsy	o yes	o no	Muscular Disease
o yes	o no	Diabetes (Type 1 or Type 2)	o yes	o no	Muscular Dystrophy
o yes	o no	Heart Murmur	o yes	o no	Seizures
o yes	o no	Irregular Heartbeat	o yes	o no	Sickle Cell Anemia
o yes	o no	Thyroid Problems	o yes	o no	Tetralogy of Fallot
o yes	o no	ADHD / ADD	o yes	o no	Heart Burn
o yes	o no	Autism	o yes	o no	Kidney Disease
o yes	o no	Down Syndrome	o yes	o no	Liver Disease
		Other Syndrome: _____	o yes	o no	Tracheomalacia

Pediatrician's Name and Phone Number: _____

Any other comments? _____

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Anesthesia Informed Consent

1. I, _____ , am asking to receive anesthesia during my dental treatment. I understand the anesthesiologist will be present during the entirety of the procedure.
2. I understand that regardless of the type of anesthesia (General or IV sedation) and the necessary associated procedures used, there are a number of risks or consequences that may occur. The following represent some, but not all, of the common foreseeable risks and consequences that can occur: sore throat, hoarseness, nausea, vomiting, injury to eyes, bruising or tenderness at the IV or IM site, or headache. **Rare but serious risks that may occur include but are not limited to changes in blood pressure, drug reactions, cardiac arrest, stroke, brain damage, nerve damage, paralysis or death, and vomiting with aspiration would require emergency transport and hospitalization.**
3. I understand that I am responsible for the costs of treating any potential complications that require additional medical treatment.
4. I understand that medications that I am taking may cause complications with anesthesia. I have informed my anesthesiologist about any medications (prescribed, over the counter or illegal) I am now taking.
5. I understand that I must not eat or drink anything after 11PM the night before the appointment. These restrictions are for the safety of the patient.
6. I CERTIFY that I have read and fully understand the above consent for anesthesia and that the explanations therein referred to were made. I acknowledge that I have had the opportunity to discuss the anesthesia with the doctors concerned and I have received answers to all questions I asked.

Name of Patient: _____ Signature: _____

Anesthesiologist: _____ Date: _____

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. A more detailed HIPPA policy is available on request.
I understand that this information can and will be used to:
1) Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers.

Signature: _____ Date: _____

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Financial Agreement

I understand that the anesthesiologist does not participate as an in-network provider with insurance plans. Upon my request, a receipt will be provided to me which will be suitable for submitting to my medical or dental insurance company to seek reimbursement; however anesthesia for dental services is rarely a covered benefit. Sleep Easy Dental takes no responsibility for limits of insurance coverage.

Payment of a non-refundable deposit of $1300 is due prior to the scheduled appointment. Remaining payment is due the day of the appointment and can be made with cash or credit card. Checks are NOT accepted. I understand the time for anesthesia includes the dentist's total treatment time, anesthesia preparation time, and recovery time. The anesthetic charges are based on the following fee schedule: $1300 for the first hour and $250 for each 15 minutes thereafter.

I understand that failure to pay for services in a timely manner may result in my account being submitted to an attorney or collection agency for collection and agree that I will be responsible for all attorney's fees and costs of collection associated therewith.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for the services listed above and will pay the provider this amount, regardless of any payment the insurance companies may send me.

□ Yes I would like an itemized receipt sent to my email: _____

Patient Name: _____

Signature of Patient/Parent: _____

Name of Payor (if different): _____

Date: _____

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Discharge Instructions

Anesthesia: Subtle residual effects of general anesthesia or sedation can last more than 24 hours. You should have a responsible adult stay with you for the next 24 hours. Rest for the remainder of the day. Although you may feel normal within the first few hours, your reflexes and mental ability may be impaired without you realizing it. You may feel dizzy, lightheaded or sleepy for a few hours after the end of anesthesia. Do not consume alcohol, drive, operate machinery or make important personal or business decisions for 24 hours. After a general anesthetic, it is normal to feel body aches and sore muscles for 24 hours. A temporary sore throat may also be present.

Diet: Avoid dairy for the first 3 hours, if it is avoidable. Clear liquids for the first couple hours (such as water, cranberry juice and Gatorade). Slowly progress to a normal diet as tolerated unless otherwise instructed by your dentist.

Medications: Your dentist may have given you prescriptions for post-operative medication or his/her office may have provided medications to you directly. If you have any reactions to any of your medications such as severe nausea, vomiting and/or skin rash, stop taking the medication and call your dentist. Local anesthesia (such as Lidocaine) is common after dental procedures, so you may be numb in parts of the mouth.
The following medications are recommended as needed for post-operative pain control:

- Acetaminophen (follow package instructions)
  - O May begin immediately O May begin at _____pm/am

-OR-

- Ibuprofen/Motrin/Advil (follow package instructions)
  - O May begin immediately O May begin at _____pm/am

-OR-

- Pain medication prescribed by dentist

Nausea/Vomiting: The most common adverse reaction after anesthesia is some nausea and vomiting. Anti-nausea medication was given to you during the procedure. If nausea/vomiting is present post operatively, limit the diet to clear fluids until the nausea resolves. If nausea is severe and prolonged, contact the anesthesiologist.

I understand all of the discharge instructions reviewed to me by the anesthesiologist or the assistant. All questions have been answered to my satisfaction. If I have any questions or problems regarding my anesthesia, I may contact the anesthesiologist at any time.

Name: _____ Signature: _____ Date: _____

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Deposit/Payment

- In order to book an appointment, a $1300.00 non-refundable deposit is required. This deposit will be credited toward your balance at the time of the appointment.
- If you fail to appear at the time of your appointment, do not correctly follow the NPO guidelines, or cancel within 48 hours of your appointment, your deposit will be forfeited.
- Sleep Easy Dental accepts credit card and cash payments only
- NO CHECKS

Cash: All cash payments will be accepted at time of the appointment. If you indicate a cash payment, we will still require a credit card to hold the appointment.

Credit Card: (American Express is not accepted)

Number: _____

Expiration Date: _____ CVC Code: _____

Billing Zip Code: _____

I hereby authorize Sleep Easy Dental to charge the above credit card for the sum of 1300.00 indicating partial payment of my anesthesia services.

Signature: _____ Date: _____

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Authorization for Use/Disclosure of Health Information

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my physician's office to use or disclose my health information to the recipient that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient:

Name: Dr. Miriam Chung DDS

Fax: 1-718-324-4601

Email: SleepEasyDental@gmail.com

Purpose: I authorize the release of my health information for continuing care

Patient's Name: _____

DOB: _____

Date: _____

Signature of Patient/Guardian: _____

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