Patient Instructions

Please complete the enclosed **ANESTHESIA PATIENT INFORMATION** form, **MEDICAL HISTORY** form and **CREDIT CARD DEPOSIT** form**. Submit** completed forms to your treating dental office or Sedadent Anesthesia Services two weeks prior to your appointment.

Read and carefully follow the **PRE-ANESTHESIA INSTRUCTIONS** that are enclosed.

Please read and keep the **FINANCIAL POLICY** and **POST-ANESTHESIA INSTRUCTIONS**.

It is recommended that you contact your insurance carrier about coverage for general anesthesia. If you would like to call your insurance companies for benefit coverage information, the CPT or procedure codes are below:

Dental Billing Code (also Aetna or TriCare Medical): D9222, D9223
All Other Medical Insurance Billing Code: 00170

Please let your insurance company know we are out-of-network providers. They may be able to cover services at an in-network rate if you're being seen at an in-network dentist.

Also, ask your doctor for a letter of medical necessity and your dental treatment notes to attach to your claim.

Please call Sedadent Anesthesia Services at 512-909-3171 if you have questions.

Read the **ANESTHESIA CONSENT FORM**. This form is not meant to scare or frighten you, but inform you. Anesthesia services in dentistry have proven to be very safe and predictable. The doctor will discuss and answer any questions that you may have before any treatment is performed. If you have questions that you would like to discuss before your appointment date, please feel free to call 512-909-3171. The doctor will also attempt to call or text you the evening before your appointment to explain what to expect during your visit. Please leave a contact number that is readily available for that call or text.

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Phone: 512-909-3171 Fax: 512-246-3678
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Anesthesia Patient Information

Today's date: _____
Patient Name (Last, First): _____ DOB: _____

Age: _____ Height: _____ Weight: _____ MALE / FEMALE

Responsible party's name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email (s): _____

Please circle the best number for doctor to reach you prior to your appointment.

INSURANCE INFORMATION

Insured's Name (Last,First): _____ DOB: _____

Dental Insurance Carrier: _____ Subscriber ID:_____

Health Insurance Carrier: _____ Subscriber ID:_____

HEALTH INSURANCE CLAIM FORM (HICF 1500) Requested: Ⓨ Ⓝ

As part of the Affordable Care Act, our office is required to record 'meaningful use data' for each patient. Please answer the following:	
RACE: ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or other Pacific Islander ○ White Prefer Not to Answer	ETHNICITY: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Prefer Not to Answer PREFERRED LANGUAGE ○ English ○ Spanish Other _____

TREATMENT INFORMATION

Estimated Length of Appointment: _____Estimated Fee:_____
Appointment Date: _____ Rendering Dentist:_____

MEDICAL INFORMATION

LIST OF CURRENT MEDICATIONS		
Medication:	Dose Given:	Frequency (i.e. 2X per day):
LIST OF KNOWN MEDICAL CONDITIONS		
1.	2.	3.
4.	5.	6.
LIST OF KNOWN DRUG ALLERGIES		
1.	2.	3.

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Medical History

Patient's name_____Date of Birth____/____/_____ Height_____ Weight_____

Street Address_____City_____State_____ Zip_____

Responsible Party's name_____Relationship to patient _____

Telephone Home ( ) _____-_____ _Mobile ( ) _____-_____ Work ( ) _____-_____

List all patient medications: _____

1. Does the patient have any allergies or reactions to medications, food or latex? Yes No
   If yes, explain _____

2. Does the patient have any congenital disability or syndrome such as trisomy 21 (Down syndrome)? Yes No
   If yes, explain_____
3. Does the patient have any heart problems such as congenital defects, murmurs, high blood pressure or shortness of breath? Yes No
   If yes, explain_____
4. Does the patient have any lung problems such as asthma, bronchitis, recent cold or flu, RSV or tuberculosis? Yes No
   If yes, explain_____
5. Does the patient have any stomach or abdominal problems such as reflux, nausea or difficulty swallowing? Yes No
   If yes, explain_____
6. Does the patient have any endocrine problems such as diabetes, thyroid problems, pancreas or other? Yes No
   If yes, explain_____
7. Does the patient have any muscular problems such as weakness, paralysis, spasticity, muscular dystrophy? Yes No
   If yes, explain_____
8. Does the patient have neurologic problems such as seizures, palsy, developmental delay, stroke, autism, ADHD? Yes No
   If yes, explain_____
9. Does the patient have any kidney problems such as kidney failure? Yes No
   If yes, explain_____
10. Does the patient have any blood problems such as hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV or transfusions? Yes No
    If yes, explain_____
11. Has the patient 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**. Thank you.

Signature_____ Date_____

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CREDIT CARD DEPOSIT/PAYMENT FOR GENERAL ANESTHESIA

PLEASE EMAIL WHEN APPOINTMENT IS MADE OR FAX TO:
512-246-3678

PATIENT NAME:_____

DENTIST OFFICE:_____ DATE SCHEDULED:_____

Please circle the type of card:

- VISA
- MASTERCARD
- AMERICAN EXPRESS
- DISCOVER
- CARE CREDIT

Credit Card #_____

EXP DATE_____ SECURITY CODE (ON BACK OF CARD) _____

BILLING ADDRESS_____

AMOUNT

- DEPOSIT - $800.00 (applied to balance)
- FULL AMOUNT (determined on the date of surgery at $200 for each 15 minutes)

Deposit is due on date of scheduling. Full amount is due on the treatment date. I authorize Sedadent Anesthesia Services to charge the above referenced card for the amount indicated. Any additional balance due after the procedure may be charged as indicated unless other arrangements have been made.

Signature _____

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Anesthesia Consent Form

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information enables patients to be better informed concerning their treatment.

I hereby authorize and request Sedadent Anesthesia Services to perform the anesthesia as previously explained to me, and any other procedures deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and this is an independent function from the surgery

I understand that procedures not discussed, but deemed necessary, may be performed. Listed below are complications that may be associated with general anesthesia. Serious complications are very rare. The alternative options for some patients include intravenous conscious sedation or nitrous oxide/oxygen sedation with local anesthesia or local anesthesia alone.

Sedadent Anesthesia Services assumes no liability for the dental treatment performed by the dentist.

Uncommon Complications Associated with General Anesthesia
Please Initial Each Line

____	Pain and/or bruising at your intravenous (IV) site	____	Sore throat and/or hoarseness
____	Muscle aches	____	Nausea and/or vomiting
____	Injuries to lip or teeth from airway instruments and/or devices	____	Headache
____	Infection at intravenous site and veins nearby	____	Unexpected drug reaction
____	Bleeding/injury to nose due to passage of tubes	____	Lung infection
____	Eye injury/infection	____	Nerve damage
____	Weakness in breathing after awakening	____	Memory loss/dysfunction

Extremely Rare Complications Associated with General Anesthesia
Please Initial Each Line

____	Heart injury due to unexpected anesthetic reaction	____	Awareness during procedure
____	Brain damage or death	____	Permanent organ damage

I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother.

I understand that non-essential personnel, including parents and relatives, are not allowed in the operating room while the patient is under general anesthesia. This policy is for the safety of the patient and to minimize the time under anesthesia.

I understand that current literature indicates there may be unknown side effects related to anesthesia, especially in children under the age of 2. More information is available at smarttots.org.

Signed_____ Print Name_____

To be completed on the day of surgery

Please complete the NPO verification below, including the signature and date:

Patient _____ has had nothing to eat or drink since _____(Date and time)

_____ _____
(patient/legal guardian signature) (Date) (Anesthesia provider signature) (Date)

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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 _____

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Financial Policy

Since everyone benefits when definitive financial arrangements are agreed upon in advance, we have prepared this material to acquaint you with our financial policy for anesthesia services. Anesthesia services provided in the office setting considerably lowers the cost of care when compared to care provided in a hospital or outpatient surgical center. Fees can be kept low by utilizing the equipment and facilities your doctor has already provided. The anesthesia fee is based on your doctor's time for the procedure. As such, the time estimate may vary based on surgical complexity or anesthesia preparation time. The anesthesia billing period is from the time you are seated until the recovery is completed.

Because of the pre-surgical preparation required by Sedadent Anesthesia Services to provide safe, quality care and the scheduling of our case to the exclusion of other offices and patients, a deposit must be paid prior to the scheduling of the case. The deposit will be applied to the total anesthesia charges the day of the procedure. The balance of the anesthesia charges will be due the day the service is provided, prior to sedation.

To confirm anesthesia services for your appointment, our office will collect a $800 minimum deposit on the day that the appointment is scheduled. If the appointment is in less than 7 days, please call the office and pay the deposit with a credit card. The deposit amount will be applied to the final balance upon completion of treatment. The fee for anesthesia includes all pre-anesthesia evaluations, Sedadent's consultations with your physicians (if necessary), all drugs, supplies, anesthetic care and recovery is billed in 15-minute increments.

Every 15 minutes $200

We accept cash, money orders, MasterCard, Visa, Discover, and American Express and Care Credit. **All payments should be made payable to: Sedadent Anesthesia Services**

INSURANCE

Although we do not accept insurance as direct payment for our services, our office will gladly assist you with the processing of your insurance form so you may be reimbursed from your insurance provider directly. Recent changes have occurred in Texas laws that have dramatically increased the coverage provided under many health insurance plans for anesthesia for dentistry. However, we still recommend that you check with your carrier before treatment to determine any policy limitation, deductible, or co-payment. We will work with you and your carrier by providing information to ensure that your claim is processed properly.

Should you have any questions regarding our services or financial arrangements, please do not hesitate to contact us.

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PRE - ANESTHESIA INSTRUCTIONS

Drinking and Eating: In order to decrease the risk of complications during anesthesia, it is VERY IMPORTANT that you do NOT have ANYTHING TO EAT OR DRINK 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. 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 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**

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POST - ANESTHESIA INSTRUCTIONS

Immediately Following: You will need approximately 30 minutes after the completion of the procedure for recovery until discharge is safe. This will allow the anesthesiologist or surgeon to treat any post-operative problems, such as pain or nausea.

Home: You should plan to have your child spend the rest of the day at home. It is advised that you or another adult stay with your child to ensure any necessary responsibilities can be taken care of.

Drinking and Eating: Your child may resume drinking immediately after your dental visit. You should begin with clear liquids (water, apple juice, Gatorade) and progress to soft foods (applesauce, yogurt, oatmeal, etc.). If soft foods are tolerated well, you may resume a normal diet.

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. *If this occurs, call* ***Sedadent Anesthesia Services*** *at* ***(512) 909-3171.***

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 your child blows his or her nose, this is normal. Your child may also have a sore throat as a result of the breathing tube for up to three days following surgery.

Pain Control: A pain medication was administered through the IV that is very similar to the drug Ibuprofen. This should last for 4 (four) hours following the visit. **Please refrain from giving any pain medication containing Ibuprofen (Motrin, Advil) unless instructed by the doctor.**

Today please give _____at _____ & _____at _____

Tomorrow please give _____at _____ & _____at _____

Seek Advice: Please call if vomiting persists beyond 4 hours, if the temperature remains elevated beyond 24 hours, or if any other matter causes concern. If you have any concerns, please call **Sedadent Anesthesia Services** at **(512) 909-3171.**

Questions or Concerns: Call Dr. _____ at _____

I understand the post-operative instructions given.

Signed_____ Print Name_____

Relationship to patient_____

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