THEDENTALANESTHESIAGROUP

P: 210-460-0271 F: 866-525-9008
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Adult Health History Form

Name _____ Home Phone _____ Cell Phone _____

Address_____

Date of Birth_____/_____/_____ Weight _____ lbs Height_____ Age _____ Sex _____

Name of Dentist _____ Name of Physician _____

Physician Phone _____ Date of last medical exam_____/_____/_____

Are you seeing any additional specialists? _____

List all medications you are taking (include vitamins, herbs, birth control pills, etc.) that are prescribed to you:
_____
_____
_____

Do you have any allergies? Yes No
If yes, to what?_____ Type of Reaction: _____

_____

1. Are you in good health? ..... Yes No

2. Has there been any change in your health in the past year? ……..... Yes No

3. Are you under the care of a Physician? ..... Yes No
If yes, for what condition? _____

4. Have you had any serious illness, operation or been hospitalized in the past 5 years?..... Yes No
If yes, for what condition? _____

5. Are you taking any medications? Please list above. ..... Yes No

6. Are you using any recreational drugs? (or other prescription drugs)…..……..… Yes No
If yes, please list. _____

7. Do you have or have you had any of the following diseases or problems? ..... Yes No

A. Damaged or artificial heart valve(s), Heart murmur, Rheumatic Heart Disease? ..… Yes No

B. Artificial joints or grafts? ……. Yes No

C. Congenital heart defect(s) or murmur? …… Yes No

D. Cardiovascular Disease: Heart Attack, Angina, Coronary Disease, High Blood Pressure or Stroke? ……..... Yes No

i) Can you walk up a flight of stairs without stopping to rest? ..... Yes No

ii) Do you get short of breath easily? ……... Yes No

iii) Do your ankles swell during the day? ……..….. Yes No

iv) Do you have any heart defects or a pacemaker? ……..….. Yes No

v) Do you have any arrhythmia or irregular heart rhythm? ……..… Yes No

8. Has your physician ever told you to take antibiotics prior to dental visits?..... Yes No
If yes, for what condition?_____

9. Do you have or have you had any of the following? Please circle all that apply.

Asthma	Bronchitis	Pneumonia
Emphysema	Tuberculosis (TB)	Chronic cough
Hay Fever/Allergies	Sinus Congestion	Diabetes
Persistent Diarrhea	Recent weight loss	Hepatitis
Jaundice	Liver disease	AIDS/HIV
FaintingSpells	Seizures/Epilepsy	Thyroid Problems
Arthritis	Painful Joints	Ulcers
Chronic Heartburn	Kidney Trouble	Swollen glands
Low Blood Pressure	High Blood Pressure	Cancer
PsychiatricProblems	Compromised Immune System	Gastric Reflux
Sinusitis	Post Nasal Drip	GERD
Sleep Apnea	Limited Mouth Opening	Stiff neck
Severe “gag” reflex	TMJ Disorder	Frequent Urination

10. Do you currently have a cold, flu, runny nose, cough, congestion of the head or chest?..... Yes No

11. Do you smoke cigarettes? ….....……..... Yes No
Packs per day?_____ How many years?_____

12. Do you have a history of alcohol use and/or drug use? ..... Yes No
If yes, what and when was last use:_____

13. Do you have any bleeding disorders? (i.e.Anemia, Sickle Cell, Prolonged Bleeding) ..... Yes No

14. Have you had surgery or radiation treatment for a tumor/cancer of your head or neck? ..... Yes No

15. Have you had general anesthesia for an operation before?..... Yes No

16. Have you had any serious trouble associated with any previous dental treatment, surgery, or any previous anesthetic? …….....…….. …..... Yes No
If yes, please explain:_____

17. Has anyone in your family had an adverse reaction to a previous anesthetic? ..... Yes No

18. Do you snore heavily or have obstructive sleep apnea? ..... Yes No

19. Do you have any condition not already mentioned? ..... Yes No

WOMEN

20.Are you currently pregnant? ..... Yes No

21. Is there any possibility that you may be pregnant? ..... Yes No

22.Are you nursing?..... Yes No

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge.

Signature of Patient/Parent/Guardian _____ Date_____

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INFORMED CONSENT FOR ANESTHESIA

The following is provided to inform patients, and/or parents of minor children of the choices and risks involved with having dental treatment under anesthesia. This information is not presented to make patients, parents, or legal guardians more apprehensive, but to enable them to be better informed concerning their treatment. There are basically four choices for anesthesia: local anesthesia, conscious sedation, general anesthesia, and/or no anesthesia. These can be safely administered in either an office, surgery center, or hospital setting.

I understand that the most frequent side effects of any anesthesia are drowsiness, nausea/vomiting, and phlebitis. Most patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired for as long as 24 hours. It is recommended that adults refrain from activities such as driving, and children remain in the presence of a responsible adult during this period. Nausea and vomiting following anesthesia will occur in approximately 10-15% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however, tenderness and a hard lump may be present up to a year.

I have been informed and understand that on rare occasions anesthesia related complications include, but are not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and pneumonia. I further acknowledge, understand and accept the extremely remote possibility that complications may require hospitalization, and/or result in brain damage, heart attack, or death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three choices of anesthesia, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk.

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 a 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.

Since medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination, I have been advised not to use alcohol or other drugs for 24 hours. Also, I have been advised not to make any major life decisions or operate any vehicle and/or hazardous device for at least 24 hours until fully recovered from the effects of the anesthetic, medications, and drugs that have been given to me or my child. I have been advised of the necessity of direct "one-on-one" parental supervision of my child for twenty-four hours following their anesthesia.

I hereby authorize and request the attending anesthesiologist from The Dental Anesthesia Group, to perform the anesthesia as previously explained to me, and any other procedure 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/dentistry. Furthermore, it is understood that the dentist anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability for the anesthesia.

I have been fully advised and completely understand the alternatives to conscious sedation and general anesthesia. I accept the possible risks, side effects, complications and consequences of anesthesia. I acknowledge the receipt of and understand both the preoperative and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result and or cure. I have had the opportunity to ask questions about my or my child's anesthesia, and I am satisfied with the information provided to me. I also understood that the anesthesia services are completely independent from the operating dentist's procedure.

I have read and understand the consent for anesthesia. I have had the opportunity to have all my questions answered regarding the risks, benefits and alternatives of anesthesia.

Patient Name_____ **Date** _____

Parent/Guardian's Name_____ **Relationship to Patient**_____

Signature_____**Witness** _____

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Financial Agreement for Anesthesia Services

Patient Name :_____ Contact Number :_____

Date of Procedure :_____ E-mail :_____

Your dentist has estimated treatment time to be: _____ hour(s) _____ minutes

Total Anesthesia Time = Dentist's treatment time PLUS 30 Minutes (15 minutes for induction and 15 minutes for recovery)

Anesthesia Fees are:

Pediatrics – up to age 13
$900 for First Hour and a Half (minimum)
$150 for each additional 15 Minutes

Adults – 14 years and above
$2,400 for the First 3 Hours (minimum)
$200 for each additional 15 Minutes

The costs of anesthesia are considerably lower in your dentist's office when compared to the cost of anesthesia services in a hospital setting. The anesthesia fee estimate is based upon the dentist's estimated operating time. The time estimated may vary based on surgical complexity or anesthesia preparatory time.

Because of the pre-surgical preparation required by our group to provide safe, quality care, and the scheduling of your case to the exclusion of other offices and patients, a deposit must be paid to secure the appointment date.

To confirm anesthesia services for your appointment, the full amount for services (based upon estimated treatment time) will be collected upfront. For pediatric patients, a deposit of $900 (for 1.5 hours of anesthesia time) is due. The fee for anesthesia includes all pre-anesthesia evaluations, consultations with physicians if necessary, all drugs, supplies, and the time of anesthesia time. If a refund for any unused time is necessary, we will issue a refund. Any additional fee for additional time will be due at time of service.

We accept:

- Cash (eligible for a 5% Discount)
- Credit/Debit cards (3% transaction fee will be applied)
- Checks

* Full payment is due on the day of the appointment; all payments not paid in full by 2 weeks after treatment day is subject to a penalty of $10 per day until complete payment is fulfilled unless a payment plan is prearranged.

Insurance
Although we do not accept insurance as direct payment for our services, our office will gladly provide receipts to attach to your insurance forms the day of surgery. I hereby authorize my doctor to release any information requested by my insurance carrier.

This AGREEMENT made by and between the undersigned PATIENT/PARENT/GUARDIAN and The Dental Anesthesia Group

Patient/Parent/Guardian shall be in default of this Agreement if the Patient/Parent/Guardian fails to pay, in full the cost of services rendered under this Agreement on the date of treatment. If the Patient/Parent/Guardian is in default of this Agreement, any and all unpaid portions of fees owed shall bear interest at the maximum rate allowed by law, compounded monthly, until collected from the date of treatment. **Any deposits will not be refundable and forfeited if not given 48 hours notice prior to cancellation.**

In the event the Patient/Parent/Guardian fails and/or refuses to make payment for services rendered under this Agreement and is in default of this Agreement, the Patient/Parent/Guardian shall be responsible for all ACTUAL costs, attorney fees and interest incurred by The Dental Anesthesia Group in the collection of the debt accumulated under this Agreement.

Patient/Parent/Guardian hereby consents and agrees that if the Patient/Parent/Guardian is in default of the payments required herein, The Dental Anesthesia Group may file a legal claim in Bexar County, Texas, rather than the County in which the Patient/Parent/Guardian is located, and further that proper venue in all disputes between the parties hereto shall be in Bexar County, Texas. This Agreement will be governed by the laws of the State of Texas. This Agreement constitutes the entire agreement by the parties and supersedes any written or oral agreement of the parties prior to the date hereof. Amendments to this Agreement may only be made in writing and signed by the parties.

I, _____, have read, understand, and agree to the above ESTIMATE of fees, terms, and conditions.

Signature of Patient, Parent or Legal Guardian: _____

Date:_____

Full Name: _____

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Pre-Anesthesia Instructions

Eating / Drinking
For anesthesia, it is of utmost importance that patients have nothing to eat or drink prior to the scheduled appointment. Failure to strictly follow these instructions could result in aspiration and may be fatal.

No food or drink after **midnight** the day prior to surgery. Medications should be taken with sips of water.

Clothing
Please wear a short sleeve loose shirt and comfortable pants. Children should be in a T-shirt and pajama pants. Do not wear makeup, **nail polish**, or fake eyelashes. Contact lenses must be removed before anesthesia. Please do not bring anything valuable or wear any jewelry.

Change in health or medications
A change in health, especially the development of a cold, cough, or fever is EXTREMELY important. Please notify our office if there is any change in your health. Your appointment may need to be rescheduled.

Transportation
If you are the patient scheduled to undergo sedation, you MUST have a separate person to transport you home after the procedure. You absolutely cannot transport yourself home so please arrange transportation ahead of time.

Initial: _____

Post-Anesthesia Instructions

Eating, Drinking, and Smoking
Limit oral intake to liquids for the first few hours. Begin with water and follow with sweet liquids such as sports drinks, clear juice and soda as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Suggestions include scrambled eggs, applesauce, yogurt, mashed potatoes, and soups. If your child is not hungry, do not force him/her to eat, but encourage as much liquid as tolerated. Absolutely **no alcoholic beverages and /or smoking** for 24 hours following anesthesia.

Activities
Do not drive and/or engage in moderate to high level physical activity for 24 hours or until the effects of the anesthetic have completely subsided. Judgment may also be impaired during this time, so please avoid making any major life decisions. For children, do not allow them to swim, bike, skate or play with other children until fully recovered.

Pain or Fever
Muscle aches and a sore throat may occur similar to the flu following anesthesia. These symptoms are very common and will usually disappear within 24 to 36 hours. Medications such as Tylenol and Advil are usually very effective and should be taken at the first sign of pain, if normally tolerated. For children, a fever of up to 101 degrees Fahrenheit may develop for the first l2 hours. Tylenol Elixir every 3 to 4 hours with plenty of liquids will tend to alleviate this condition as well as treat any post-operative discomfort.

Seek Advice
If vomiting occurs and persists beyond 5 hours, if temperature remains elevated beyond 24 hours, or if you have other serious concerns following anesthesia, please contact Dr. Ayyash at 817-405-9248. In the event of a serious medical emergency, please call 911.

I, _____, have read and understand the given instructions.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

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Credit Card Authorization Form

Thank you for deciding to use The Dental Anesthesia Group for your dental anesthesia needs. As an added convenience for our patients we have provided the option of taking care of your financial arrangements with scheduled charges to your credit card.

By signing this form I, _____, am authorizing The Dental Anesthesia Group to charge my credit card identified below on the date(s) stated below. Should my credit card payment be rejected or denied by the credit card company for any reason, I understand that I am still obligated to pay The Dental Anesthesia Group the amounts owed on the designated date(s) listed below and hereby agree to make a full payment.

Payment Amount: $_____+ Additional anesthesia time balance (To Be Determined)

Payment Due Date: _____ (day before scheduled treatment)

Credit Card Number: _____-_____-_____-_____

Security Code: _____

Expiration Date: _____

Name on Credit Card: _____

Billing Address: _____

Email: _____

Billing Zip Code: _____

Billing Phone Number: _____

Signature of Cardholder: _____

Date: _____