IV SEDATION TREATMENT

The scheduled dental treatment requires that the patient receive anesthesia through IV Sedation. A professional with special expertise will perform this procedure. This individual will be specifically scheduled to be present at the time and place of your child's procedure to administer the anesthesia.

We require VERBAL CONFIRMATION of your child's sedation appointment. The office will call you 48 hours before the appointment date with the time and instructions. It is your responsibility to VERBALLY CONFIRM with the office that you will be keeping your child's appointment. If the office does not hear from you by 12:00 PM (noon) the day prior to your appointment, the office will cancel your child's appointment in order to use that time for another patient.

We require a **minimum** of twenty-four (24) hour notice to cancel a scheduled IV Sedation appointment, so we can schedule another child who may be waiting for this service and avoid any loss of income for the anesthesiologist and the dentist.

If we do not receive 24-hour notice, a **$100 charge** will be applied to your account for our office costs.

The IV Sedation appointment is scheduled for: _____.

The anesthesiologist scheduled for that day is: _____.

The amount of time estimated for treatment: _____.
***Val *will need this information when you call her.*

Please contact the above anesthesiologist regarding the anesthesia/IV Sedation at:
(724) 759-7948 Val

Should you have any questions regarding the dental treatment, please contact our office at (412) 257-1150.

PARENT OR GUARDIAN'S ACKNOWLEDGEMENT

I hereby acknowledge having received a copy of the office policy relating to Dissociative Anesthesia procedures. I understand that a one hundred dollar ($100.00) charge shall be added to my account in the event that I cancel the scheduled appointment without providing a minimum of twenty-four (24) hour notice.

Patient's Name: _____

Patient's Date of Birth: _____

_____ _____
Parent and/or Legal Guardian's Signature Date

Premiere Anesthesia for Dentistry

Preoperative History & Physical Exam

Patient Name: _____

Height: _____ BMI: _____ DOB: _____

Weight: _____ Sex: _____ Age: _____

Medical History Please circle within normal limits (WNL) or describe any deviation from WNL.

General:	WNL	_____
Neuro/Psychiatric:	WNL	_____
Cardiac:	WNL	_____
Pulmonary:	WNL	_____
Hematology/Bleeding history	WNL	_____
Endocrine	WNL	_____
Musculoskeletal	WNL	_____
Other:	WNL	_____

Physical Assessment

Eyes	WNL	_____	Neck	WNL	_____
Nose	WNL	_____	Heart	WNL	_____
Oral Cavity	WNL	_____	Chest	WNL	_____
Throat	WNL	_____	Abdomen	WNL	_____

Medications (attach list if necessary) _____

Surgical history (attach list if necessary) _____

Allergies (attach list if necessary) _____

Anesthetic, Family, and Social History

Has the patient ever had IV sedation or general anesthesia? Circle one: YES NO

Is there any family history of complications with anesthesia? Circle one: YES NO

List any other pertinent family history
(cardiac, pulmonary, bleeding disorders) _____

Are there any smokers in the household? Circle one: YES NO

Adult Patients	Alcohol Use Yes/No If yes, # drinks per day___	Tobacco Use Yes/No If yes, type of tobacco and describe (e.g. packs per day)	Drug Use Yes/No If yes, describe drugs used and frequency

Please attach any recent lab work or studies that the patient has received (e.g. EKG, echo, HbA1c level, etc.)

Are there any contraindications to this patient receiving IV sedation/general anesthesia? Circle one: YES NO

(If yes, please explain)

Reviewing Physician's Name: _____ Physician's Signature: _____

Office Phone Number: _____ Date of Exam: _____

Office Fax Number: _____