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IV Sedation Pre-Op Form

Name _____ Home Phone _____

Cell Phone _____

Address _____

Date of Birth _____ Weight _____ lbs BMI _____

Height _____ SpO₂ _____ Blood Pressure _____

Male / Female

Name of Dentist _____

Name of Physician _____

Physician Phone _____

Date of last medical exam _____

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

Do you have any allergies? Yes No

Please list allergy and reaction: _____

Please circle the correct response.

- 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 these diagnosed? Please mark all that apply.

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

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
 If yes, please list: _____

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 _____

Reviewed by:

Printed name: _____ Signature: _____

Date _____

Informed Consent for Anesthesia

Initial _____ 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.

Initial _____ 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 can occur in 15-30% 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. Nerve damage from local anesthesia administration may also be permanent.

Initial _____ I have been informed and understand that on rare occasion's 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, stroke, 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.

Initial _____ **FEMALES:** 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 Dr. _____ 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.

Initial _____ 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. Since the patient's memory will be impaired for 24 hours, someone other than the patient is expected to monitor and control all post operative medications.

Initial _____ I hereby authorize and request the providing doctor _____ 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. I understand that the doctor has no responsibility for the dental treatment to be performed, the diagnosis, or the treatment planning involved. Dr. _____ sole attention and responsibility will be to render the optimal and safest anesthetic. 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.

Initial _____ I acknowledge the pre-operative fasting regulation and attest that they were followed. The patient has had nothing by mouth for at least eight (8) hours immediately prior to the appointment, with the exception of clear liquids, which may be taken up to two (2) hours prior to the appointment.

Initial _____ 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 postoperative 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. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure.

Initial _____ I authorize Alcan Dental Group, LLC to release my information to associated parties, medical physicians, and insurance companies; in order, to provide and bill for the best possible anesthetic experience.

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 _____

(Consent to be signed by patient, parent or legal guardian)

Pre-Anesthesia Instructions

Eating or Drinking

Failure to strictly follow these instructions could result in aspiration and may be fatal. For anesthesia, it is of utmost importance that patients have an empty stomach.

No food of any kind for 8 (eight) hours prior to the appointment.

Water or Gatorade, may be taken up to 2 (two) hours prior to the appointment.

Clothing

Please wear a short sleeve loose shirt. Children should bring a blanket. For children who do not wear a diaper or pull up, please bring an extra set of clothes. 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 Dr. _____ if there is any change in your health. Your appointment may need to be rescheduled. Prescription medications should be taken as scheduled unless previously indicated by Dr. _____ and may be taken only with sips of water.

Designated Driver

A responsible adult must accompany any patient to the office and remain during the procedures. Do not plan on driving or making decisions for twenty-four (24) hours after the anesthesia. Arrange to have a responsible adult to spend the rest of the day with you. Young children should be in a car seat during the ride home.

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. Place a blanket on the floor for the child to rest and observe him/her closely.

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 2 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 our office at **(907) 562-4774** to speak with one of our staff or your doctor. In the event of a serious medical emergency, please call 911.