ARIZONA ANESTHESIA FOR DENTISTRY

INFORMED CONSENT for ANESTHESIA

Patient Name:_____ Patient Date of Birth:_____

The following is provided to inform patients, and/or parents/guardians 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. ***Initials:***_____

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 crucial that adults refrain from activities such as driving, and children remain in the presence of a responsible adult during this period. ***Initials:***_____

I 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, stroke, malignant hyperthermia, 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 least risk and genera! Anesthesia the greatest risk. ***Initials:***_____

I consent, authorize and request the administration of such anesthetic(s) 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 of the anesthesia and this is an independent function from the surgery/dentistry. Furthermore, it is understood that the anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability for the anesthesia. ***Initials:***_____

I understand Arizona Anesthesia for Dentistry will safeguard my health information based on the rights given to me under the Health Insurance Portability and Accountability Act (HIPAA). ***Signature:***_____

Females: I understand that anesthesia may be harmful to the unborn child and may cause birth defects or spontaneous abortions. I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant, a confirmed pregnancy, and/or being a nursing mother). ***Signature:***_____

I have been made fully aware and completely understand the alternative to general anesthesia. I accept the possible risks, side effects, complications and consequences of anesthesia. I acknowledge the receipt of and understand both preoperative and post-operative instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result. 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.

Please print name:_____ Relationship:_____

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

PHONE: 623-200-1996 FAX: 520-300-7330 EMAIL: ASAAD@AZA4D.COM WWW.DRASAADKHAN.COM

ARIZONA ANESTHESIA FOR DENTISTRY

ANESTHESIA INSTRUCTIONS for ADULTS

You have been scheduled to receive dental treatment under Anesthesia. The medications that will be administered to you will allow you to undergo the dental treatment safely and comfortably. The following instructions must be followed. FAILURE to follow these instructions could put you at unnecessary risk and result in CANCELLATION of the appointment.

EATING AND DRINKING

- **NO** solid food by mouth after **MIDNIGHT.**
- **WATER UP TO 4 MEASURED OUNCES MAXIMUM** may be consumed up to **4 HOURS** prior to the appointment.
- **NO MILK OR OTHER DAIRY PRODUCTS** may be consumed.

CLOTHING

Please come to the office in comfortable, loose fitting clothes. Please **AVOID ALL JEWELRY, MAKE-UP, AND NAILPOLISH** as it can interfere with the procedure. We encourage all of our patients to wear compression socks before anesthesia as it possibly helps with blood clot formations in the legs.

MEDICATIONS

IF YOU ARE TAKING ANY MEDICATIONS, please contact our office **FIRST** before your appointment so that the anesthesiologist can tailor your anesthesia plan accordingly. If applicable, please have **ALL RECENT BLOODWORK, CARDIAC TEST REPORTS, PULMONARY REPORTS –AND– ANY OTHER TESTING AND REPORTS** faxed to your dental office so the anesthesiologist can review them and discuss an appropriate anesthesia plan with your doctor and specialists.

SICKNESS

Please contact our office as soon as possible to report any changes in general health, persistent-fever, productive cough, illness, etc.

ESCORT

At the completion of the appointment, at least **1 ADULT** is required to take you home. At home, please make sure there is 1 adult supervising **EXCLUSIVELY** for at least **3 HOURS**.

NO PARENT OR FAMILY MEMBER is allowed to remain in the treatment area after you are under anesthesia.

Please bring a pillow and blanket for the ride home. Do not change your daily routine prior to the appointment.
Please **DO NOT STAY UP LATE** the night before the appointment or eat too late.

If you have any questions or concerns about these instructions, please contact our office: 623-200-1996

Patient/Guardian Signature:_____ Date:_____

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Post-Anesthesia Instructions

- **Recovery from Anesthesia**
  You will be invited to sit with the patient during recovery from anesthesia. They will most likely be asleep when you are escorted to recovery. You may notice markings on the skin from medical tape that was used to secure vital sign monitors, IV and oxygen supply. These markings are only temporary and will disappear with time. Also, you may expect the lips to be swollen. It is normal to have some mild pain and bruising at IV and injection sites.

  Most people find waking up from anesthesia to be unpleasant, especially children. Most people feel tired, weak, cranky, and upset. Patients may also experience dizziness, blurred vision, dry mouth, crying, shivering, numbness, itchy nose and/or eyes, and general frustration about not feeling "normal". All of these side effects wilt resolve with time. Fortunately, medicine induced amnesia prevents most patients from remembering the uncomfortable feeling of waking up from anesthesia.

- **Eating and Drinking**
  Limit oral intake to liquids for the first few hours. Begin with water and follow with sweet liquids such as sports drinks, clear juice as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Suggestions include applesauce, mashed potatoes and soups. Please stay away from heavy or greasy foods today. If your child is not hungry, do not force him/her to eat but encourage as much liquid as tolerated.

- **Activities**
  Do not drive and/or engage in moderate to elevated level physical activity for 24 hours or until the effects of the anesthesia have completely subsided. Judgment may also be impaired during this time. For children, do not allow them to swim, bike, skate or play with other children until fully recovered. Place a blanket on the floor or couch for the child to rest and observe him/her closely.

- **Pain or Fever**
  Muscles aches and a sore throat may occur similar to the flu following anesthesia. These symptoms are very common and will usually disappear within 24to 36 hours. Medications such as Tylenol (Acetaminophen) and Advil (Ibuprofen) are usually very effective and should be taken at the first sign of pain, if normally tolerated. Please use as directed for patient age and weight. For children, a fever of up to 101 degrees Fahrenheit may develop for the first 12 hours.

- **Medications**
  Resume taking any prescribed medications once fluids are tolerated. If you received prescriptions for the procedure, take those as directed following the appointment.

- **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 Arizona Anesthesia for Dentistry at: 623-200-1996.
  If there is no answer, please leave a message and we will promptly return your call.

  In the event of a serious medical emergency, please call 911

PHONE: 623-200-1996 FAX: 520-300-7330 EMAIL: ASAAD@AZA4D.COM WWW.DRASAADKHAN.COM

ARIZONA ANESTHESIA FOR DENTISTRY

Contact Form

Patient Name:_____ **Patient Date of Birth:**_____

Given the amount of time and preparation to coordinate two separate offices, it is immensely important both offices can get in contact with you prior to the appointment please provide TWO separate phone numbers in addition to your main contact number. If any of the numbers below change prior to the scheduled appointment, please contact the office to update them immediately.

Main Contact name:_____ Phone Number:_____

Second Contact name:_____ Phone Number:_____

Third Contact name:_____ Phone Number:_____

****YES, you need to provide THREE different contacts****

If either office is unable to get a hold of you four days prior to the schedule appointment your appointment will be cancelled. **NO EXCEPTIONS**. It is our utmost priority to contact and appropriately prepare patients and parents for the appointment. Please note if your case is Fee-for-service your deposit will **NOT** be refunded for lack of communication. Your signature below indicates your understanding and acceptance to this policy.

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Please print name:_____ Relationship:_____

Patient/Guardian Signature:_____ Date:_____

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ADULT | PATIENT REGISTRATION

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight: _____

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

Home Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY:

Name of Person/Relationship: _____ Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

MEDICAL HISTORY:

Have you ever had any of the following medical problems?

Y N Allergy to Latex
Y N Allergies to Medications (Please list below)
Y N Asthma/Lung Problems
Y N High Blood Pressure
Y N High Cholesterol
Y N Heart Murmurs/Defects
Y N Heart Surgery
Y N Other Surgery _____
Y N Seizure Disorder (Epilepsy)
Y N Autism
Y N Diabetes
Y N Down Syndrome
Y N Other Syndromes _____
Y N Possibly PREGNANT (Women >10 years old)

Y N Cerebral Palsy
Y N Handicaps/Disabilities
Y N Hemophilia
Y N Parkinson's Disease
Y N Alzheimer's Disease
Y N Tuberculosis
Y N Mastocytosis
Y N Tracheal Malacia
Y N Cancer
Y N Muscular Dystrophy
Y N Sickle Cell Anemia
Y N Malignant Hyperthermia (Patient or Familial History)

Please discuss any medical problems that you have/had: _____

_____

Are you currently under the care of a physician? Yes No Date of Last Visit: _____

Physician Name: _____ Phone Number: _____

Are you followed by a SPECIALIST? Yes No *Please indicate ALL that apply*: Cardiologist Endocrinologist

Geneticist Hematologist Neurologist Oncologist Pulmonologist Other _____

Please list ALL current medications: _____

Please list ALL allergies (medicine, food, latex, etc.): _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform the doctors of Arizona Dental Anesthesia of any changes in the medical status of this patient at the earliest possible time.

Signature of Parent or Legal Guardian: _____ Date: _____

Reviewed by: _____ Date: _____

VIP
Family & Solutions Dentistry

830 S Main Street 1-D
Cottonwood, AZ 86326
928-634-5566

Dr. Massoud Eftekhari
www.VIPdentistryAZ.com

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other: _____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Are you taking any BLOOD THINNER? Yes No If yes please list: _____

9. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No

ARIZONA
ANESTHESIA
FOR DENTISTRY

INVOICE for GENERAL ANESTHESIA

Name:_____

Date of Birth:_____

Date of Service:_____

Amount: $_____ Paid in Full to Arizona Anesthesia for Dentistry, PLLC

Dental Office:_____

Dr. Khan
Board Certified Dental Anesthesiologist

15990 S. Rancho Sahuarita Blvd, Suite 110, Sahuarita, Arizona 85629

TIN: 81-0834201
NPI: 1578655916
Fax: (520) 300-7330

D9222 General Anesthesia, First 15 minutes Unit:_____ Fee: $_____

D9223 General Anesthesia, Each Additional 15 minutes Unit(s:_____ Fee: $_____

Total Fees: $_____

Method of Payment: _____

_____

THANK YOU FOR YOUR BUSINESS