TEXAS ANESTHESIA CARE

Welcome,

We consider it a great honor to be anesthesia providers and to participate in your care as an individual. We have provided these materials for you to review prior to your anesthesia experience. These materials are meant to help put you at ease and to provide an understanding of the anesthesia process. All information you provide is strictly confidential and will only be used to help us make important decisions concerning your anesthesia care. For this reason, please be completely honest while answering all the provided questions. Please feel free to reach out to us with any questions that you may have.

You may call or text us at 210.503.7200 or you may visit our website at: www.texasanesthesiacare.com

We look forward to meeting you!

TEXAS ANESTHESIA CARE

Patient Identification Page

Patient Name _____ Date of Birth _____/_____/_____ Sex M / F

Height _____ Weight _____ Emergency Contact _____ Contact # _____

Patient address _____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____

Please circle

Race: Asian American Indian/Alaska Native Black/African American

Native Hawaiian/Pacific Islander White/Caucasian

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Preferred language: English Spanish Other _____

Insured's Name _____ Date of Birth _____/_____/_____

Dental Insurance Carrier _____ Subscriber ID _____

Pre-Authorization Number (if patient is 6 years or younger) _____

Health insurance carrier _____ Subscriber ID _____

Referring Dentist _____

TEXAS ANESTHESIA CARE

HIPPA and Privacy Policy Acknowledgment Document

Patient Name _____ Date of Birth ____/____/_____

The HIPAA Privacy Rule mandates that health care providers distribute a Notice of Privacy Practices to all patients. This document outlines how protected health information about an individual may be used and disclosed and under what circumstances specific authorization from the individual may not be required. The Notice of Privacy Practices also describes the HIPAA defined patient rights related to use and disclosure of the individual's health information. Please carefully review the Texas Anesthesia Care Notice of Privacy Practices. This document is available as a hard copy in paper form and is additionally available on the website, texasanesthesiacare.com.

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

If you have any questions about this notice, please contact our office at 210.503.7200

The HIPPA Notice of Privacy Practices can be viewed in its entirety by visiting our website: www.texasanesthesiacare.com

Signature of Patient or Parent/Guardian_____

Print Name _____

Date _____

TEXAS ANESTHESIA CARE

Patient Name _____ Date of Birth _____/_____/_____ Sex M / F

Height _____ Weight _____ BMI _____ Emergency Contact _____ Contact # _____

Please answer all questions to the best of your knowledge, please list any and all medical conditions in the areas provided, your answers are strictly confidential. Your answers to these questions are vital in helping us administer general anesthesia in a safe manner.

Do you have any of the following diseases or medical problems:

1. Heart problems. Including any of the following: high blood pressure, chest pain, tightness, pressure, heart attack, irregular heart beat, pacemaker/defibrillator, circulation problems, heart failure.

Please describe: _____ ☐ No

2. Can you walk up two flights of stairs without stopping for rest? Y / N

3. Lung Problems. Including any of the following: history of smoking, asthma, emphysema, bronchitis, shortness of breath at rest, recent cough or cold. Have you ever been diagnosed with or been suspected of having sleep apnea?

Please describe: _____ ☐ No

4. Neurological problems. Including any of the following: stroke or mini stroke (TIA), seizures, back or neck problems, physical restrictions/limitations, multiple sclerosis, multiple dystrophy, spinal/nerve injury, neuropathy.

Please describe: _____ ☐ No

5. Kidney or Liver Problems. Including any of the following: diabetes, thyroid disease, kidney disease, trouble urinating, liver disease, hepatitis, heartburn (GERD, reflux).

Please describe: _____ ☐ No

6. Blood problems. Including any of the following: abnormal bleeding, sickle cell disease, history of blood transfusions, HIV/AIDS, anemias.

Please describe: _____ ☐ No

7. Any conditions from birth (congenital conditions) or syndromes. Including any of the following: Down Syndrome, autism, ADHD, developmental delay, cerebral palsy, other syndromes.

Please describe: _____ ☐ No

8. Are you taking any heart or blood pressure medications including beta blockers. Y / N

Please list all medications and dosages:_____ ☐ No medications

9. Please list all allergies to medications or otherwise, including food and materials such as latex:

_____ ☐ No allergies

10. Please list all surgeries or anesthesia events, including any problems with anesthesia. Have any blood relatives have a history of problems with anesthesia?

_____ ☐ No

I have read and understood the questions and have answered these questions truthfully and to the best of my ability.

Signature: _____ Date: _____

TEXAS ANESTHESIA CARE

Pre- and Post-Anesthetic Instructions

If you are planning to undergo dental treatment under sedation or general anesthesia, please carefully review the instructions below to help ensure a safe anesthetic experience.

Instructions Prior to Anesthesia

It very important that all food and liquids, including water, milk, breast milk be stopped midnight before the appointment. It is important that you follow these instructions as any food or liquids (along with acid) present in your stomach may be aspirated (inhaled into your lungs).
This is a potentially serious and fatal risk that is easily minimized by following our instructions and by being honest with your anesthesiologist if you have accidentally had any food or drink.

( ) Initials

You may take your medications with a small sip of water unless otherwise instructed by the anesthesiologist

If you were prescribed an antibiotic pre-medication, please take the antibiotic as scheduled at least 1 hour prior to arriving.

Please wear short sleeves, flat shoes, and comfortable shorts or pants. Contact lenses should not be worn to the office. Please remove any nail polish, make-up, lotion, oils, powders, watches, and jewelry prior to arriving to the office. Leave all valuables at home.

You must have a responsible adult drive you to the office and wait with you. Please have your driver contact information available to us as you will not be permitted to drive yourself home.

You must inform the anesthesiologist of any change in your health prior to your appointment.

No smoking for 12 hours prior to surgery.

Patient Signature _____

Instructions Following Anesthesia

Plan to have a responsible adult drive you home. Do not plan to drive or operate potentially dangerous equipment for 24 hours after your anesthesia.

A responsible adult should be with you until the next day.

You should start drinking some water, Gatorade, or apple juice after your appointment. If you can tolerate drinking these clear fluids, you may advance your diet as tolerated. Avoid foods with dairy (e.g. milk, cheese, yogurt) and food that is too hot or too spicy. No alcoholic beverages for 24 hours after the anesthesia.

Nausea or vomiting may occur after anesthesia. If it persists beyond 4 hours, please contact your anesthesiologist.

If your temperature is persistently elevated following anesthesia, please contact your anesthesiologist

If you have any additional concerns, please contact your anesthesiologist or Texas Anesthesia Care main office at 210.503.7200

Your Anesthesiologists contact info: _____

I have read, understand, and received a copy of these instructions.

Patient Signature_____

TEXAS ANESTHESIA CARE

CONSENT FOR ANESTHESIA

This information is provided to inform you of the choices and risks involved with having treatment under anesthesia. This is also provided to help you feel more comfortable and enable you to be better informed concerning your treatment. There are basically four choices for anesthesia: Local anesthesia, conscious/deep sedation, general anesthesia, or no anesthesia. These can be administered, depending on each individual patient's medical status, in a hospital or in a private office. The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. You are encouraged to explore all the options available for your, or your dental procedure under anesthesia and to consult with your dentist/oral & maxillofacial surgeon or pediatrician as needed. **( ) Initials**

The most frequent side effects of any general anesthetic are drowsiness, nausea and vomiting, and phlebitis (inflammation at the IV site, this may last for some time). Some patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired. It is recommended that adults refrain from activities such as driving and children remain in the presence of a responsible adult for 24 hours **( ) Initials**

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. **( ) Initials**

I have been informed and understand that occasionally there are complications of the drugs and anesthesia including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, stroke, brain damage, and heart attack. I further understand and accept the risk that complications may require hospitalization and even may result in death. I have been made aware that the risks associated with local anesthesia, conscious/deep sedation, and general anesthesia will vary. **( ) Initials**

I hereby authorize and request Texas Anesthesia Care, PLLC 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 that this is an independent function from the surgery/dentistry. **( ) Initials**

I have been advised of and completely understand the risks, benefits and alternatives of general anesthesia. I accept the possible risks and dangers. 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 anticipated anesthesia and am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist/oral and maxillofacial surgeon. The anesthesiologist assumes no liability from the surgery/dental treatment performed while under anesthesia and that the dentist/oral and maxillofacial surgeon assumes no liability from the anesthesia performed. **( ) Initials**

Print Patient's Name: _____ Phone number: _____

Print Patient/Guardian Name (if applicable):_____ Date: _____

Signed: _____ Witness: _____

TEXAS ANESTHESIA CARE

FINANCIAL AGREEMENT AND POLICIES FOR ANESTHESIA SERVICES

Patient Name _____ Date _____

Procedure _____

Estimated treatment time: _____

Estimated anesthesia fee: _____

Anesthesia fees are:

- **For the first sixty minutes of care (Including any time up to 60 mins.): $1000**
- **For each additional fifteen minutes (15 mins): $250**
- **For care lasting longer than 3 hours, please contact us directly for special arrangements.**

Anticipated method of payment (circle one):

Cash Debit Visa / Mastercard Care Credit

The estimated anesthesia fee is based upon the dentist's estimate of treatment time, anesthesia preparatory time and the patient's response to the anesthetic used.

Payment for anesthesia services is due the day of treatment, unless otherwise arranged. In the event anesthesia time exceeds the estimate, the patient is responsible for the additional charges.

Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company regarding your benefits. We will be happy to provide a receipt for the anesthesia services.

A nonrefundable deposit of $500 may be collected prior to the date of the scheduled treatment. This deposit is credited toward the total anesthesia fee. Cancellation of the scheduled appointment less than 48 hours prior will result in the loss of this deposit or you will be charged a cancellation fee of $500.

I understand that if I fail to pay the fees (a returned check or failure to pay the balance in the event of a financial arrangement), I will be charged an interest of 18% APR and will be liable for all the collection charges and or court fees.

I have read, understand and agree with the above estimate of fees and policies.

Print Patient's Name_____ Phone_____

Signature of Patient_____ Date_____