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 you understand 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.

To help you better prepare for your appointment there is additional information you can review on our website at:
https://www.texasanesthesiacare.com/welcome

You may access this page on our website by scanning this QR code with your electronic device:

On our website you can find additional information including common questions and contact information.

We look forward to meeting you!

TEXAS ANESTHESIA CARE

Patient Identification Form

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

Height _____ Weight _____ Emergency Contact _____ Contact # _____

Patient address _____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____

Please indicate with a check mark below:

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) _____

IF YOU HAVE SECONDARY INSURANCE, PLEASE FILL OUT THE SECONDARY INSURANCE INFORMATION BELOW, YOUR INSURANCE CLAIM WILL BE AFFECTED IF INFORMATION IS MISSING.

Health insurance carrier _____ Subscriber ID _____

Referring Dentist _____

Please verify that you are the legal guardian and have the legal right to make medical decisions for this patient by initialing here. **Initials (___)**

TEXAS ANESTHESIA CARE

HIPPA and Privacy Policy Acknowledgment Form

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_____

TEXAS ANESTHESIA CARE

Patient Medical History Form

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.

If after careful review of each of each section you find that your child has not been diagnosed with any of the listed conditions, please indicate by checking the 'No' box.

Does your child have any of the following diseases or medical problems:

1. Heart problems. Including any of the following: heart murmurs, congenital heart defects, heart attack, blood pressure problems, irregular heart beat, pacemaker/ defibrillator, circulation problems, rheumatic heart disease, Kawasaki's disease.

Please describe: _____ No ☐

2. Has your child ever been diagnosed with a heart murmur? If your child has been evaluated by a cardiologist or has been under the care of specialist for their heart condition please describe below.

Please describe: _____ No ☐

3. Lung Problems. Including any of the following: asthma, bronchitis, shortness of breath at rest, recent productive cough, cystic fibrosis. Please document the date of the most sickness resulting in a fever, cough, cold, vomiting, sore throat, runny nose and/or rash.

Please describe: _____ No ☐

3. Neurological problems. Including any of the following: stroke or mini stroke (TIA), seizures, back or neck problems, physical restrictions/limitations, multiple sclerosis, muscular dystrophy, spinal/nerve injury, neuropathy. *If your child has a seizure disorder, please list the type and frequency of seizures. Please document the date of the most recent seizure event.*

Please describe: _____ No ☐

4. 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 ☐

(Medical history questions continued on next page)

TEXAS ANESTHESIA CARE

Patient Medical History Form (continued)

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

Please describe: _____ No ☐

6. Do you have a family history of sickle cell disease or sick cell trait; or has your child been diagnosed with any of these conditions?

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 any genetic or inherited syndromes or medical conditions including any bone, muscle or nerve disorders.

Please describe: _____ No ☐

8. Please list all medications and dosages that your child is taking including over the counter medications, vitamins and natural/homeopathic substances on a routine basis. Please also list any medications that have been prescribed but are currently not being administered.

_____

_____

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 had problems with anesthesia?

_____ None ☐

11. Please list any hospitalizations your child may have had including the reason for the hospitalization and date.

_____ None ☐

12. Please document and describe the reason for any referrals your child may have received to a medical specialist.

_____ None ☐

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-Anesthesia Instructions

Please carefully review the instructions below to help ensure a safe anesthetic experience. As the parent, you are responsible for ensuring that your child strictly adheres to these instructions.

Instructions Prior to Anesthesia

It very important that all food and liquid, including water, milk and breast milk be stopped 8(eight) hours before your appointment. For example, if your child's appointment is at 6am, all food and drink should stop at 10pm the night before. It is important that you follow these instructions as any food or liquids (along with stomach acid) present in your child's stomach may be aspirated (inhaled into the lungs). This is a potentially serious and fatal risk that is easily minimized by following our instructions and by being honest with your anesthesiologist. The parent or legal guardian must watch their child or dependent very carefully for the 8(eight) hours prior to their appointment time.

Initials (___)

You may give your child their prescription medications with a small sip of water unless otherwise instructed by the anesthesiologist. Of note, routine medications for asthma, diabetes, thyroid, skin and other conditions should be taken on the day of the appointment.
If you were prescribed an antibiotic pre-medication, please have your child take the antibiotic as scheduled at least 1 hour prior to arriving.

Please have your child wear short sleeves, flat shoes, and comfortable shorts or pants. Please avoid one-piece outfits (pajamas that cover their feet) for your children as it makes applying some of our monitoring devices difficult. 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. It is encouraged that you bring your own small blanket with you.

For patients who are under foster care or temporary custody; legal documentation must be provided to the anesthesia provider. The Anesthesia provider will review your child's medical history prior to beginning the treatment. If your child or dependent is receiving treatment, you must stay at the office while your child is receiving treatment.

You must inform the anesthesiologist of any change in your child's health prior to your appointment. If your child begins experiencing cold or flu like symptoms, please notify the anesthesia team. If your child or dependent has tested positive for COVID, or if they have continued to experience extended COVID symptoms, please notify the anesthesia team.

To help you prepare for your appointment, please review the information found in the '*Day of your appointment tab*' at www.texasanesthesiacare.com. If you are cannot find the answers to your questions on this paperwork or the website listed above, please email: info@texasanesthesiacare.com. We can be also be reached at (210) 503-7200.

All children, dependents and minors need to be accompanied by their legal guardian.

Signature of Parent or legal guardian _____

TEXAS ANESTHESIA CARE

Instructions Following Anesthesia

It is normal for your child to feel tired, groggy and irritable after anesthesia, but he/she should respond to physical or verbal stimulation. Waking up from anesthesia can be disorienting and uncomfortable for anyone, especially children. Many times children will cry because they have a difficult time understanding the sensations that accompany anesthesia.

Reflexes and coordination will be delayed and/or slow following anesthesia. It is imperative that you do not allow your child to be overly active while recovering from anesthesia. Do not allow them to participate with sports, trampolines, swimming pools, parks, playgrounds, bicycles or other similar activities. Please allow your child to relax for the remainder of the day in a temperature controlled environment. They may resume activities the following day as they feel comfortable.

If your child received an IV during the procedure there are a few things to keep in mind. Please discourage them from picking at or touching the IV site; it is best to keep the IV site clean for a few days as it heals. Minor bruising will often accompany the IV site, this is normal. Large bruising that covers a large portion of the limb along with red, swollen, tender and/or hot sores around the IV site are not normal and you should contact our team to evaluate the condition.

If your child received a breathing tube (endotracheal intubation tube) their throat may be dry and scratchy. This is usually self-limiting and will go away in a few days. Cold liquids are the best things to help their throat fell better, e.g., cold juice, popsicles, jello, etc. Sometimes the breathing tube will cause a nose bleed. If your child's nose begins to bleed this is not unexpected, especially if they are rubbing their nose or sneezing. The nose bleed can be managed as a typical nose bleed with pressure or cold compress and a tilted-back head position. If the nose bleed does not stop or significantly slow down after 15 minutes you should call our team.

Nausea and vomiting are common after surgery. To minimize symptoms, lie down and avoid dairy products. Start slow with clear liquids and small amounts of food for the first couple of hours after anesthesia. If your child becomes nauseous following any food or water, stop all food and water for one hour and allow the nauseas to pass. If your child is consistently nauseous for over four (4) hours following your arrival at home, please call for our team to help evaluate the condition; we may call in a prescription for nausea.

A fever following anesthesia is common. This fever is often self-limiting and goes away after 24 hours with Tylenol and ibuprofen. If the fever is unusually high (>101°F) or lasts for longer than 24 hours, please call our team to have your child's condition evaluated.

Your child's diet should include clear liquids for the first several hours after surgery (water, apple juice, ginger ale, Gatorade, etc.). Fluids are important to prevent dehydration. Their first meal should consist of soft foods (Jell-O, mashed potatoes, etc.) in moderate quantities. If this is well tolerated, you may gradually advance their diet to solid foods. If you child is diabetic, maintain their normal diet as much as possible, and follow your doctor's instructions regarding their insulin schedule.

If your child is sensitive to tape or adhesives they may have a localized reaction. The most common sites for a reaction involves the area around the eyes and the areas where tape helped

secure the IV site. When this localized reaction happens around the eyes, it can create the appearance of 'raccoon eyes'. This is usually caused by a reaction to the adhesive on the paper tape that is used to protect the eyes during the procedure. During recovery, we recommend the child does not rub their eyes. Lightly dabbing the closed eyes with a cool clean washcloth is ok if your child is complaining of itchy eyes.

To help with the discomfort caused by the dental treatment, we recommend a combination of ibuprofen and acetaminophen (Tylenol). Use the dosing instructions printed on the bottle. For any concerns with pain or discomfort or questions regarding the dental treatment including anything occurring with the lips, teeth or gums, we recommend you contact the dental office; we do not participate in the dental treatment portion of your child's procedure.

It is common for the dentist to administer local anesthesia to your child's mouth during the procedure to provide a more comfortable experience. This local anesthesia can last for a few hours. The dentist will recommend that you watch your child to ensure they do not bite their cheek or lip. If you have any questions about local anesthesia for your child we recommend you talk with the treating dentist.

IF YOUR CHILD IS ALLERGIC TO TYENOL OR IBUPROFEN PLEASE ALERT THE ANESTHESIA TEAM, DO NOT GIVE YOUR CHILD THESE MEDICATIONS IF THEY ARE ALLERGIC.

During the procedure your child is often given a medication that is similar to ibuprofen(if they are not allergic to this type of medication). For this reason we recommend starting with Tylenol within three hours after you arrive home. Following the first Tylenol does, we recommend giving your child ibuprofen(Motrin) at the appropriate time. You may alternate the two medications every 3 hours until bedtime. It is ok to continue this regimen through the night and the following day if needed.

First Tylenol dose (follow dosing on bottle according to weight): _____

First Ibuprofen dose (follow dosing on bottle according to weight): _____

Second Tylenol dose (follow dosing on bottle according to weight): _____

Second Ibuprofen dose (follow dosing on bottle according to weight): _____

Third Tylenol dose (follow dosing on bottle according to weight): _____

Third Ibuprofen dose (follow dosing on bottle according to weight): _____

Our phone number is listed below. Do not hesitate to call if you have any questions or concerns.

Tel: 210-503-7200

For any emergencies involving trouble breathing or a lack of response to firm verbal and physical stimulation, call 911 immediately.

TEXAS ANESTHESIA CARE

CONSENT FOR ANESTHESIA

This information is provided to inform you of the choices and risks involved with having treatment under anesthesia. It is intended to help you feel more comfortable and better informed concerning your dependents 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 dental procedures 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 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 child's, 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 Parent or Legal Guardian's Name:_____ Date: ____/____/_____

Signature: _____ Witness: _____

Please verify that you are the legal guardian and have the legal right to make medical decisions for this patient by initialing here. **Initials (___)**

TEXAS ANESTHESIA CARE

FINANCIAL AGREEMENT AND POLICIES FOR ANESTHESIA SERVICES

Patient Name _____ Date ____/____/____

Procedure _____

The estimated treatment time is 90 minutes. If the anesthesia time is less than 90 minutes, reimbursement will follow the fee schedule provided below. The total time will be calculated after the procedure is completed. If the procedure takes longer than estimated, you will be responsible for paying the additional cost.

Anesthesia fees are:

< 60 mins: $1000
< 90 mins: $1250
< 120 mins: $1500
≥ 120 mins: $1750

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_____

Print Parent/Guardian's Name_____ Date ____/____/_____

Signature_____