PATIENT INSTRUCTIONS

DreamGuard Anesthesia is committed to providing safe, office-based anesthesia for dental procedures. It is important that you discuss the details of the procedure, including its risks and benefits, and have all of your questions answered prior to receiving care. Please read through and complete the enclosed forms.

The **Anesthesia Patient information** and **Medical History forms** will help us tailor your care to your specific needs. The **pre- and post-Anesthesia Instructions** will help you prepare for your upcoming appointment. All forms of anesthesia have associated risks. The **anesthesia consent** form is meant to inform you of these risks. The combination of today's sophisticated anesthesia equipment, modern anesthetic medications and superior anesthetic techniques performed by our providers help to make anesthesia in the outpatient setting safer than ever. Submit completed forms to your treating dental office or to DreamGuard Anesthesia Services two weeks prior to your appointment.

- ✓ **Anesthesia Patient Information**
- ✓ **Medical History**
- ✓ **Pre-Anesthesia Instructions**
- ✓ **Post-Anesthesia Instructions**
- ✓ **Financial Policy**
- ✓ **Credit Card Deposit**
- ✓ **Anesthesia Consent Form**
- ✓ **HIPAA Form**

If you have questions that you would like to discuss before your appointment date, please feel free to call **(281) 323-2925**. The doctor will also attempt to call or text you the evening before your appointment to explain what to expect during your visit. Please leave a contact number that is readily available for that call or text.

PRE-ANESTHESIA INSTRUCTIONS (ADULT)

Food & Drinks: For anesthesia, it is extremely important that patients have an empty stomach. Do not eat or drink anything, for eight (8) hours before your dental procedure. Clear liquids may be consumed until two (2) hours before your scheduled procedure. Clear liquids include water, apple juice or Gatorade. Do not eat, drink, chew gum, or suck on candy. Consuming food or non-clear liquids within eight (8) hours of your procedure will result in the rescheduling of your appointment. FAILURE TO STRICTLY FOLLOW THESE INSTRUCTIONS COULD RESULT IN ASPIRATION AND MAY LEAD TO SERIOUS, LIFE -THREATENING COMPLICATIONS.

Transportation: Due to the lingering effects of anesthesia, all patients must have a responsible adult companion physically present in the office to escort you home. This person must remain at the office during the procedure and drive you home. Patients may not go home alone by taxi, uber, or bus. For your safety, you should not operate or drive any vehicle for twenty-four (24) hours after surgery, or while you are taking pain medication.

Personal: Wear loose fitting, comfortable clothes with a short-sleeved shirt. You may bring a small blanket from home. Avoid wearing long sleeved shirts or jeans. Do not wear contact lenses or nail polish the day of your procedure.

Health: If you start to develop or show signs of a cold, fever, or any other acute illness, call your dentist's office immediately. Congestion of the nose or chest may compromise the airway. To reduce the risks of anesthesia, patients with signs of illness the day of their procedure will be rescheduled.

Medications: Prescription medications should be taken as scheduled with a small sip of water or postponed if directed by your doctor. Bring a list of all medicines you are now taking including the dosage and how often you take the medicines.

Arrival: Patients who arrive late may have to have their surgery rescheduled for another day. The anesthesiologist reserves the right to cancel or postpone the scheduled appointment for any reason that may jeopardize the safety of the anesthetic procedure.

Questions: Your anesthesiologist will contact you the day before your scheduled procedure. Please feel free to contact us if you have additional questions or concerns.

_____
Date

_____ _____
Patient Name Signature

POST-ANESTHESIA INSTRUCTIONS (ADULT)

After your procedure: When your dental procedure is complete, the anesthesiologist will reverse the medications to wake you up. You may feel a bit groggy or sleepy when you first wake up and will need about 30 minutes for recovery until discharge is safe. During this time, the anesthesiologist will closely monitor recovery and post-operative issues like pain or nausea.

Transportation: Due to the lingering effects of anesthesia, all patients must have a responsible adult companion physically present in the office to escort you home. This person must remain at the office during the procedure and drive you home.

Food & Drinks: As soon as the patient is able, encourage fluid intake beginning with clear liquids (water, Gatorade, apple juice). Once clear liquids are tolerated, slowly allow the patient to try soft foods (applesauce, scrambled eggs, mashed potatoes). You may resume a normal diet when soft foods are tolerated well. Avoid dairy products and greasy food for the remainder of the day, as these may cause nausea.

Medicine: Continue medications as prescribed unless otherwise indicated by your doctor.

Health: Patient may experience a low-grade fever following anesthesia. Patient should stay indoors and remain in a cool, temperature-controlled area. Occasionally, nausea may occur following anesthesia. Anti-nausea medication was administered through the patient IV during the procedure. If the patient experiences nausea or vomiting after discharge, restrict diet to clear liquids (see above), until symptoms subside. **If patient is experiencing persistent nausea or vomiting, please contact the anesthesiologist**.

Intravenous Site (IV): You may experience some discomfort at the IV site following your procedure. Bruising or tenderness is normal and should subside shortly.

Breathing tube: The anesthesiologist will typically place a breathing tube through the right or left side of the nose for intubation. A small percentage of patients may experience redness or minor nose bleeds. You may also have a sore throat as a result of the breathing tube for up to three days following anesthesia.

Pain Control: It is not uncommon for patients to experience pain after a dental procedure. A pain medication was administered through the IV that is very similar to the drug Ibuprofen. This should last for four (4) hours following the visit. **Please refrain from giving any pain medication containing Ibuprofen (Motrin, Advil) for 4 hours following discharge.** Tylenol can be given immediately as needed for pain.

If the patient is experiencing persistent pain after taking recommended medications, please contact the dentist.

_____ _____

Patient Name Signature Date

ANESTHESIA PATIENT INFORMATION (CONFIDENTIAL)

Today's date: _____
Patient Name (Last, First): _____ DOB: _____

Age: _____ Height: _____ Weight: _____Gender: Male / Female

Responsible Party's Name:_____
Address: _____ City: _____ State: _____Zip: _____
Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____
Email(s): _____
What is the best way to contact you prior to your appointment? _____
Emergency Contact Name: _____ Phone: _____

Insurance Information

Insured's Name (Last, First): _____ DOB: _____
Dental Insurance Carrier: _____ Subscriber_____
ID:_____ Health Insurance Carrier: _____
Subscriber ID:_____
Health insurance claim form (HICF 1500) Requested: Y ◯ N ◯

As part of the Affordable Care Act, our office is required to record 'meaningful use data' for each patient. Please answer the following:
Race: [ ]American Indian or Alaska Native. [ ]Asian [ ] Black or African American
[ ] Native Hawaiian or other Pacific Islander [ ]White [ ]Prefer Not to Answer
Ethnicity: [ ]Hispanic or Latino [ ] Not Hispanic or Latino o Prefer Not to Answer
Preferred Language: [ ]English [ ]Spanish [ ]Other _____

Treatment Information

Estimated Length of Appointment: _____Estimated Fee:_____
Appointment Date: _____ Rendering Dentist:_____

Medical Information

Current Medications

Medication	Dose Given:	Frequency (ie 3x per day)

Known medical conditions:
Known drug allergies:

FINANCIAL POLICY

It is the goal of DreamGuard Anesthesia (DGA) to provide you with the highest quality of anesthesia care at a reasonable cost. Providing anesthesia services in the dental office setting significantly lowers the cost of treatment when compared to the cost of treatment in a hospital setting. It is important that you discuss the details of the procedure, including costs and coverage, and have all of your questions answered prior to receiving care. This document is intended to inform you of the fee structure and process for the anesthesia care provided by your Dentist Anesthesiologist. It also explains to you your financial responsibility for services rendered. Please reach out to us if you have any additional questions.

- ✓ **Anesthesia Fee** estimate is based upon the dentist's estimated operating time, which will vary with the anesthesia preparatory time and patient's individual response to the anesthetic agents used. The anesthesia fee includes pre-anesthesia evaluations, consultations with your physicians (if necessary), all drugs, supplies, anesthetic care, and recovery. The anesthesia billing period is from the time you are seated until recovery is complete. Payment for anesthesia charges will be due the day of treatment, prior to sedation, less any deposits made. If the anesthesia time exceeds the estimate, the Patient will be responsible for the additional charges. If the anesthesia time is less than the estimate, the patient will receive a pro-rated refund.
    - Your dentist has ESTIMATED your treatment time to be: _____
    - Anesthesia time (approximately treatment time plus 30minutes): _____
    - Anesthesia fees are**: $250 for every 15 minutes**
    - **Anesthesia Fee Estimate**: $_____
- ✓ **Deposit:** To schedule anesthesia services for your appointment, a deposit of $1000 is required. This deposit will be applied to your final balance the day of treatment.
- ✓ **Insurance**: Insurance companies vary in coverage, but most policies do not cover anesthesia in the dental setting. Some dental and medical insurance plans might provide reimbursement for anesthesia services rendered for dental procedures. It is your responsibility to submit for insurance reimbursement directly to your insurance company after you make full payment for services rendered. Ask your dentist for a letter of medical necessity and for your dental treatment notes to attach to your claim. DGA is not enrolled in-network with any medical or dental providers. If covered, services may be covered at an in-network rate if your dentist is an in-network provider. Please note the following billing codes when contacting your insurance:
    - CPT or procedure codes: Dental Billing Code (also Aetna or TriCare Medical): D9222, D9223.
    - All Other Medical Insurance Billing Code: 00170
- ✓ Payment can be received via cash or credit card (Visa, MasterCard, American Express and Discover cards). The patient or guardian will be responsible for the cost of any returned checks. There will be a fee assessed for all reimbursements amounting to the processing fee charged by your credit card/ care credit or a minimum of $50.

_____ _____

Patient Name Date

_____

Patient Signature

Credit Card Deposit

Patient Name: _____ DOB:_____

Dental Office:_____ Date of Procedure: _____

A deposit of $1000 is due at the time the appointment is made. This will be applied to the final bill for anesthesia services. Full payment for the remaining balance is due the day of treatment prior to anesthesia.

Credit Card Information
Card Type: (circle one) MasterCard Visa Discover Amex Other:
Cardholder Name (as shown on card):_____
Card Number: _____ Exp. Date (mm/yy):_____ Cvv Code (3 digit number on back of card):_____
Billing Address: _____Zip Code:_____
Amount: $

I, _____, authorize DreamGuard Anesthesia to charge my credit card referenced above for the amount indicated. Any additional balance due after the procedure may be charged as indicated unless other arrangements have been made.

_____ _____

Patient Name Date

_____

Patient Signature

MEDICAL HISTORY

Patient's Name:	Date of Birth: / /	Height:	Weight:
Street Address:	City:	State:	Zip:
Responsible Party's Name:	Relationship to patient:		
Phone: Cell	Home:	Work:	

Has the patient ever had any of the following?

1. Heart Conditions (congenital defects, shortness of breath, pacemaker, murmur, high blood pressure) If yes, please explain:_____	Yes ❑ No ❑
2. Blood conditions (anemia, easy bruising/bleeding, hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV) If yes, please explain:_____	Yes ❑ No ❑
3. Lung conditions: (emphysema, shortness of breath, TB, asthma, recent cold or flu, RSV) If yes, please explain:_____	Yes ❑ No ❑
4. Digestive tract or abdominal conditions (stomach ulcers, reflux, nausea, difficulty swallowing): If yes, please explain: _____	Yes ❑ No ❑
5. Infectious conditions: (AIDS, hepatitis, herpes/cold sores) If yes, please explain: _____	Yes ❑ No ❑
6. Endocrine conditions (thyroid, parathyroid disease or calcium deficiency, diabetes) If yes, please explain:_____	Yes ❑ No ❑
7. Autoimmune Conditions: (rheumatoid arthritis, lupus) If yes, please explain:_____	Yes ❑ No ❑
8. Neurological conditions (epilepsy, seizures, autism, ADHD, stroke) If yes, please explain:	Yes ❑ No ❑
9. Muscular problems (weakness, paralysis, muscular dystrophy) If yes, please explain	Yes ❑ No ❑
10. Congenital disabilities or syndromes, like Trisomy 21 (Down Syndrome): If yes, please explain:	Yes ❑ No ❑
11. Kidney Problems: (kidney failure)	Yes ❑ No ❑
12. Has the patient or any blood relatives ever had problems with general anesthesia?	

Please list all serious medical conditions or hospitalizations and dates:

Please list all surgical operations and dates:

Please list all allergies (food, medicine, latex, etc):

I understand that withholding or misrepresenting any information about my health could seriously jeopardize my safety. I have carefully reviewed the above medical health history and answered all questions to the best of my knowledge. I understand it is my responsibility to inform the doctors of Dream Guard Anesthesia of any changes in medical status.

_____ _____

Patient Signature Date

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA)

Patient Name: _____ Date of Birth: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The DreamGuard Privacy Practices notice describes how health information about you may be used and disclosed and how you can get access this information. You may request a copy of our Privacy Notice at any time. Our Privacy Policy can be found on our website: www.DreamGuardAnesthesia.com

Please read over our Privacy Policies then sign below.

I have received and read through DreamGuard's Privacy Policy.

Print Name: _____ Date: _____

Signature: _____

DREAMGUARD ANESTHESIA

DISCLOSURE AND CONSENT - ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia.*

I voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

I understand that anesthesia/analgesia involves additional risks and hazards but I request the use of anesthetics/analgesia for the relief and protection from pain or anxiety during the planned and additional procedures. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐ ___GENERAL ANESTHESIA – injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.

☐ ___REGIONAL BLOCK ANESTHESIA/ANALGESIA - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.

☐ ___SPINAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ ___ EPIDURAL ANESTHESIA/ANALGESIA - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ ___ DEEP SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ MODERATE SEDATION – memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

Additional comments/risks:

☐ _____PRENATAL/EARLY CHILDHOOD ANESTHESIA - potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

_____

_____

I understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent.

This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

_____

DATE: _____ TIME: _____ A.M. /P.M.

WITNESS:

_____
Signature

_____
Name (Print)

_____
Address (Street or P.O. Box)

_____
City, State, Zip