Dear Patient,

Welcome, your oral surgeon has recommended that your dental treatment be provided using intravenous sedation/general anesthesia should be administered by a Physician Anesthesiologist . The medications used will allow you to “sleep” through the procedure in a safe, controlled, and monitored setting thus allowing your dentist to provide the highest quality of dental care.

I would like to take this opportunity to share with you the services I provide that will enable you to achieve a positive experience during your dental treatment. My mission is to provide the highest standards of patient care and safety, in the comfort, convenience, and familiar surroundings of your dentist’s office.

Prior to scheduling your anesthesia appointment, you will need to complete the following forms and return them to my office:

- Medical History
- Preoperative/Postoperative Instruction & Consent
- Financial Agreement

Please take the time to review the enclosed forms, sign and date each of them, and fax, email or mail them to my office. Because of the extensive time, effort, and coordination necessary to schedule patients, ***I require a non-refundable deposit of $750*** prior to scheduling your appointment. Please contact my office to arrange payment.

The evening prior to your appointment, Dr. Plavin or his partner will personally phone you between the hours of 6pm-9pm. At that time, he will review your health history, explain the anesthesia appointment in careful detail, and answer any questions that you might have concerning your anesthesia services.

- Wear loose, comfortable pants and a short-sleeved shirt.
- Bring a change of clothes.
- Bring a warm blanket.
- Nothing to eat or drink six hours prior to your appointment unless otherwise instructed.

On the day of treatment, Dr. Plavin or his physician partners will monitor your heart rate, blood pressure, oxygen saturation, respirations, and body temperature. An intravenous line will be established and medications will be titrated as needed to keep you comfortable, pain free, and asleep throughout the dental procedure. Accompanying adults (spouse/friends) will remain in the reception area during the entire treatment. If you have additional questions, please contact my office. I look forward to serving your anesthesia needs with the highest quality of care and safety.

Sincerely,

Stanford R. Plavin MD

Oral Surgery Anesthesia Associates LLC
P.O. Box 76295
Atlanta, GA 30358

Stanford R. Plavin MD

"I have dedicated my anesthesia practice to providing the highest standard of patient care and safety. I personally attempt meet with each patient to discuss his or her medical history and conduct a limited physical exam. I explain my patient's treatment in careful detail and answer all questions in an unhurried atmosphere. My goal is to provide quality anesthesia care to each patient, relieve any discom-fort, and help our patients achieve a positive experience during their dental or oral surgical treatment."

EDUCATIONAL BACKGROUND

- Residency in Anesthesiology: Emory University Affiliated Hospitals, Atlanta, GA.
- MD: University of Vermont College Of Medicine, Burlington, VT.
- BSc.: McGill University, Montreal, Quebec, Canada

RECOGNIZED AS AN EXPERIENCED HEALTHCARE PROVIDER

- Residency trained Physician Anesthesiologist, specifically disciplined in providing sedation and general anesthesia care in a variety of clinical settings: Hospital Operating Rooms, Outpatient Surgical Centers, and Dental,Oral surgery and Physician Offices. Providing experience, safety, and quality anesthesia care for over 20 years.

A COMMITMENT TO CONTINUING EDUCATION

- Frequently attends annual meetings of the American Society of Anesthesiologists and completes over 40 hours of continuing Medical education each year.
- Lecturer: U.S. and internationally, to various organizations on topics such as Office Based Anesthesia, Patient selection for Office based surgery, ASC lecturer, Infection control, Oral Sedation, Deep Sedation, General Anesthesia, and other related topics.
- Maintains current certification in BLS, ACLS and PALS.

PROFESSIONAL AFFILIATIONS

- American Society of Dentist Anesthesiologists- Affiliate
- American Society of Anesthesiologists
- International Anesthesia Research Society
- Society for Ambulatory Anesthesia
- ASCA Board Member

ACTIVE MEMBER OF THE COMMUNITY

- Dr. Plavin has two children, resides in Atlanta and is active in organized medicine and anesthesiology on a local, state and national level. He enjoys quality time with his family, children, sports, travel and music

P.O. Box 76295, Atlanta, Georgia 30358 * Phone (888)-717-0080 * Fax (404)-549-2853

ADULT MEDICAL HISTORY FORM

Patient's Name: ____________________________ Date of Birth ______ / ___ / ______ Age: _____Weight:______________________
Address: ____City: _______________State: ________ Zip: ____________
Home Telephone: (____) ____ Cell (____) ______________________

Dentist Office Name: ____________________________________

List all medications you are currently taking: ____
____
____

Do you have allergies to any medications or foods? Yes / No If yes, which? ____

1. Are you in good health? ____ Yes/No
2. Are you currently under the care of a physician? ____ Yes/No
3. Have you had any serious illness, operation, or been hospitalized in the last 5 years? ____________________________ Yes/No
4. Do you have or have you had any of the following heart diseases or complications?
   Congenital heart defects or murmurs? ____ Yes/No
   Damaged heart valves, malfunctioning heart valves, or artificial heart valves? ___________________________________ Yes/No
   Arrhythmias or irregular heart beats? ____ Yes/No
   Ventricular septal defect or atrial septal defect? ____ Yes/No
5. Do you have or have you had in the past any of the following cardiovascular complications?
   Chest pain upon exertion? ____ Yes/No
   Shortness of breath after mild exercise or when lying down? ____ Yes/No
   Stroke or transient ischemic attack? ____ Yes/No
   High blood pressure? ____ Yes/No
   Swelling in the ankles? ____ Yes/No
   Heart transplant? ____ Yes/No
6. Do you have or have you had any of the following lung diseases or complications?
   Current cold or flu symptoms? ____ Yes/No
   Chronic sinus problems or seasonal allergies, chronic cough? ____ Yes/No
   Bronchitis, pneumonia, emphysema, tuberculosis? ____ Yes/No
   Asthma or reactive airway disease? ____ Yes/No
7. Do you have or have you had any of the following diseases or complications?
   Diabetes? ____ Yes/No
   Thyroid disease? ____ Yes/No
   Kidney disease? ____ Yes/No
   Liver disease (hepatitis or jaundice)? ____ Yes/No
   Stomach problems (ulcers, excess stomach acid w/heart burn, persistent diarrhea and or weight loss)? _______________ Yes/No
   Arthritis, swollen and painful joints and lymph nodes? ____ Yes/No
   Seizures (epilepsy), fainting spells, or other neurological problems? _______________________________________ Yes/No
   Mental retardation, autism, or any other problems with mental health? ______________________________________ Yes/No
   Cancer? ____ Yes/No
   Sexually transmitted diseases, HIV, AIDS? ____ Yes/No
8. Do you bruise easily or have you ever been diagnosed with bleeding disorder? _______________________________ Yes/No
9. Do you have any blood disorders such as Anemia or Sickle Cell Anemia? __________________________________ Yes/No
10. Have you spent time in an intensive care unit? ____ Yes/No
    Were you intubated for a prolonged period of time? ____ Yes/No
    Did you go home with oxygen? ____ Yes/No
11. Have you or any blood relative ever had a bad reaction to anesthesia? ____________________________________ Yes/No
12. Do you have any disease, condition, or complication not mentioned above? __________________________________ Yes/No
    If yes, please explain: ____
    ____
    ____

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge.
Signature: ____ **Printed Name:** __________________ **Date:** ___/____/_____

Dr. Stanford R. Plavin MD

PRE-ANESTHESIA INSTRUCTIONS

Eating or Drinking

It is extremely important that patients have an empty stomach. Vomiting of stomach contents during anesthesia is life threatening. For this reason, adults are not to have anything to eat or drink for eight (8) hours before their scheduled appointment. Children should not have any food or drink for six (6) hours before their scheduled appointment. A parent must supervise children on the day of the appointment. Do not leave your child unattended or send your child to school/day care on the day of surgery.

Change in Health

Any change in health, especially the development of a cold, cough, flu or fever is extremely important information for the anesthesiologist. Please notify our office immediately if there is any change in your health or the health of your child.

Medications

Prescription medications should be taken as scheduled, only with a sip of water, unless previously discussed by the anesthesiologist.

Street Drugs

The literature has reported that the use of "Street Drugs" (marijuana, cocaine, amphetamines, etc.) mixed with an anesthetic can result in serious complications including death. Therefore, street drugs are strictly forbidden for several weeks prior to any anesthetic.

Clothing and Contacts

Short sleeves, loose fitting pants and comfortable shoes are advised. Do not wear makeup, nail polish, or false eyelashes. Contact lenses must be removed before anesthesia. Please leave all valuables at home. For children, bring a change of clothing and a warm blanket. If possible, have your child wear a diaper.

Designated Driver

A responsible adult must accompany the patient to the office and remain during the procedure. You will not be allowed to leave by taxi or bus. Arrange to have a responsible adult spend the rest of the day with you. Do not plan on operating any equipment for twenty-four (24) hours after the anesthesia.

Questions

Prior to your anesthesia, Dr. Plavin or his partner will contact you to discuss your anesthesia and answer any questions that you may have. Failure to abide by these instructions will result in cancellation of your appointment and forfeiture of your deposit.

__________ **Initial**

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 sport drinks, clear juice and soda as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Soft foods we suggest are 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 12 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 24hrs, or if you have other serious concerns following anesthesia, please contact: **Dr.** Plavin @ 404-242-6360. In the event of a serious medical emergency, please call 911.

__________ **Initial**

I HAVE READ, UNDERSTOOD, AND RECEIVED A COPY OF THE ABOVE INSTRUCTIONS:

SIGNED ____ DATE________________________

P.O. Box 76295, Atlanta, Georgia 30358 * Phone (888)-717-0080 * Fax (404)-549-2853

Dr. Stanford R. Plavin MD

INFORMED CONSENT FOR ANESTHESIA

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 an office, surgi-center, or hospital setting.

I understand that 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 will occur in approximately 10% - 15% 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. _______________

Initial

I have been informed and understand that on rare occasions anesthesia related complications occur including, but 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, heart attack, or death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesias vary. Of the three choices of anesthesia, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk. _______________

Initial

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 responsibly for informing the dentist 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. _______________

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. _______________

Initial

I hereby authorize and request the attending anesthesiologist, Dr. Stanford Plavin or his partners 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. 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 have been fully advised and completely understand the alternatives to conscious sedation and general anesthesia. I accept the possible risks, side affects, complications and consequences of anesthesia. 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 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 dentists procedure. _______________

Initial

I consent to the taking of photographs and/or video during the procedure solely for educational use: YES ____ NO ____
I have read, understand the consent for anesthesia, and had the opportunity to have all my questions answered regarding the risks & benefits of anesthesia.

Signed____ Date ____/_____/____
(Consent to be signed by patient, parent or legal guardian)

Print Name____ Witness ______________________________

Patient Name____

FINANCIAL AGREEMENT FORM FOR ADULT

Patient's Name: ____ Date of Procedure ____________________

Your dentist has **ESTIMATED** your dental treatment time to be approximately: __________

ANESTHESIA FEES ARE BASED ON UNITS OF TIME:

$750 for the first 30 minutes of anesthesia

$125 for each additional 15 minute increments

The minimum charge for anesthesia services is $1,250

Dr.Plavin or his partners anesthesia treatment time is the **TOTAL** of dental treatment time **PLUS** an additional 1 hour: __________

INITIAL 30 MINUTES: $750

ADDITIONAL TIME ($125 X _____): __________

TOTAL **ESTIMATED** ANESTHESIA: $__________

LESS DEPOSIT: -$750

____

ESTIMATED TOTAL DUE THE DAY OF SURGERY: ____________ ______ **Initial**

PAYMENT FOR ANESTHESIA SERVICES ARE DUE IN FULL THE DAY OF THE TREATMENT

I, the patient/parent/guardian, acknowledge full responsibility for the payment of anesthesia services. I understand that by signing this document, I am agreeing to pay **Dr. Stanford Plavin or his partners** his full fee for anesthesia services on the day services are rendered. If the anesthesia time exceeds the estimate, the patient/parent/guardian will be responsible for the additional fee. If the anesthesia time is less than the estimated time, the patient/parent/guardian will be charged based on the actual anesthesia time. Payment for the anesthesia services may be paid by VISA/MASTERCARD/DISCOVER/AMEX or CASH. **No checks accepted**.
____ **Initial**

NON REFUNDABLE DEPOSIT POLICY

Due to the fact that it takes great time, effort and coordination between the offices of the oral surgeon and the anesthesiologist to schedule your appointment an NON REFUNDABLE DEPOSIT of $750 is required prior to your anesthesia appointment. Failure to comply with the eating and drinking instructions will result in a cancelation of your appointment and forfeiture of your deposit. Prior to the anesthesia appointment the financial agreement must be signed and accompany the deposit. Deposits may be received by one of the following methods; Cash, Cashiers Check, Money Order, or Credit Card (name, number, v-code, and expiration date written in the below space). ______ **Initial**

INSURANCE INFORMATION

It is important that reimbursement for the anesthesia fee by dental or medical programs **NOT** be assumed. Many insurance policies **DO NOT** pay for anesthesia services for dentistry. Please check with your Dental or Medical Insurance Company representative as to the benefits included. Dr. Plavin will be delighted to provide you with a "Anesthesia Statement of Services Form" at the end of your appointment so that you can submit it to your insurance company for reimbursement. ______ **Initial**

Signing below authorizes the office of Dr. Stanford R. Plavin and OASS effective immediately to perfrom a credit card transaction in the form of a sale charging $750.00 as a non-refundable deposit to be applied towards the fee for the anesthesia services listed above. If the anesthesia services cannot be performed or administered as planned because the patient does not appear at the agreed time or failed to follow the preoperative eating or drinking instructions, this deposit will be forfeit. This deposit will be applied towards future anesthesia by Dr. Plavin , only if he determines that the patient is too ill to safely proceed at the scheduled time.

I have read, agreed, and received a copy of the financial agreement and the deposit policy.

SIGNED ____________________________ PRINTED NAME ____________________________ DATE ____________

PAYMENT OF DEPOSIT

Method of Payment:
CASH CREDIT CARD MONEY ORDER OTHER

Amount of deposit $ ______________ Received by: ________________________ Date ____________________

Credit Card #:____________________ V Code ____________________________ Expiration Date ______________

Address of Card Holder (including zip code)____

Telephone Number: ____________________________

Deposit Amount: $ ______________ Card holder acknowledges responsibility for payment of the non-refundable deposit and agrees to perform the obligations set forth in the cardholder's agreement with the issuer.

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