Dear Patient,

Welcome, your dentist 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 dentalcare.

We would like to take this opportunity to share with you the services we provide that will enable you to achieve a positive experience during your dental treatment. Our 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 the dentist's office or via fax. We also have an online registration option at www.oralsurgeryanesthesiaassociates.com Utilize the patient info- registration to do so

- Medical History
- Preoperative/Postoperative Instruction & Consent
- Financial Agreement (separate)

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, ***We typically require a deposit and payment with your dentist*** prior to scheduling your appointment. Please contact our office to arrange payment as well as the dentist's to confirm the process.

- Wear loose, comfortable pants and a short-sleeved shirt.
- Bring a change of clothes.
- Bring a warm blanket.
- **Nothing to eat or drink 8 (eight) hours prior to your appointment unless otherwise instructed**.
- **May have clear liquids only (water/sprite/apple juice) up to 4 hours prior, but NOTHING after that if scheduled for procedure after 12 noon. Call site or practice for instructions.**

On the day of treatment, one of the board certified anesthesiologists with OSAA 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 our office or your pediatric dentist's office. We 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
5825 Glenridge Drive, Building 3, Suite 101-123
Atlanta, GA 30328

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 (egg/soy)? Yes/No If yes, which? _____

1. Are you in good health? _____ Yes/No
2. Are you currently under the care of a pediatrician? _____ Yes/No
3. Have you had any serious illness, operation, or been hospitalized in the last 6 months? _____ 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 heartbeats? _____ 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 _____ Yes/No
   - High blood pressure? _____ Yes/No
   - Other: _____ 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
   - Anxiety or depression _____ Yes/No
   - Premature birth history _____ 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 neonatal 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
13. If yes, please explain: _____
    _____
    _____

SIGNED BY PARENT/GUARDIAN _____ DATE_____

5825 Glenridge Drive, Bldg 3, Ste 101-123, Atlanta, GA 30328
Phone(888)-717-0080 FAX: (404) 902-5716

PRE-ANESTHESIA INSTRUCTIONS

Eating and 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 solid food/breast milk after midnight prior to surgery. **Clear Liquids allowed 4 hours prior to surgery NOTHING AFTER THAT TIME**. Call for instructions.! 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 (IF APPLICABLE)

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, one of the anesthesiologists will contact you to discuss your anesthesia and answer any questions that you may have. Failure to abide by these instructions could 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 l2 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: Your dentist's office- 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_____

5825 Glenridge Drive, Bldg 3, Ste 101-123, Atlanta, GA 30328

Phone(888)-717-0080 FAX: (404) 902-5716

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/deep sedation, general anesthesia, and/or no anesthesia. These can be safely administered in an office, surgery 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 anesthestics 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 from Oral Surgery Anesthesia Associates LLC 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 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 dentist's 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_____

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