# Patient/Guardian Instructions

Please complete the enclosed **ANESTHESIA PATIENT INFORMATION** form, **MEDICAL HISTORY** form and **CREDIT CARD DEPOSIT** forms**. Submit** completed forms to your treating dental office two weeks prior to your appointment.

Read and carefully follow the **PRE-ANESTHESIA INSTRUCTIONS** that are enclosed.
Please read and keep the **FINANCIAL POLICY** and **POST-ANESTHESIA INSTRUCTIONS**.

It is recommended that you contact your insurance carrier about coverage for general anesthesia. If you would like to call your insurance companies for benefit coverage information, the CPT or procedure codes are below:

Dental Billing Code (also Aetna or TriCare Medical): D9222, D9223
All Other Medical Insurance Billing Code: 00170

Please let your insurance company know we are out-of-network providers. They may be able to cover services at an in-network rate if you're being seen at an in-network dentist.

**Also, ask your doctor for a letter of medical necessity and your child's dental treatment notes to attach to your claim.**

Please call Sedadent Anesthesia Services at 512-909-3171 if you have questions.

Read the **ANESTHESIA CONSENT FORM**. This form is not meant to scare or frighten you but inform you. Anesthesia services in dentistry have proven to be very safe and predictable. The doctor will discuss and answer any questions that you may have before any treatment is performed. If you have questions that you would like to discuss before your appointment date, please feel free to call 512-909-3171. 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.

# Anesthesia Patient Information

Patient's Name_____ Date of Birth____/____/_____ Age _____

Height_____ Weight_____ Sex: ☐Male or ☐Female

Street Address_____City_____ State_____ Zip_____

Mobile Phone (  ) _____-_____ Alternate Phone (  ) _____-_____ Email _____

Responsible Party's Name _____Relationship to Patient _____

Dental Insurance Carrier: _____ Subscriber ID:_____ Group Number: _____

Health Insurance Carrier: _____ Subscriber ID:_____ Group Number: _____

Insurance Policy Holder Name: _____ Insurance Policy Holder Date of Birth: _____

## Medical History

List all patient medications: _____

1. Does your child have any allergies or reactions to medications, food or latex? ☐Yes ☐No
   If yes, explain _____
2. Does your child have any congenital disability or syndrome such as trisomy 21 (Down syndrome)? ☐Yes ☐No
   If yes, explain_____
3. Does your child have any heart problems such as congenital defects, murmurs, high blood pressure or shortness of breath? If yes, explain_____ ☐Yes ☐No
4. Does your child have any lung problems such as asthma, bronchitis, recent cold or flu, RSV or tuberculosis? ☐Yes ☐No
   If yes, explain_____
5. Does your child have any stomach or abdominal problems such as reflux, nausea or difficulty swallowing? ☐Yes ☐No
   If yes, explain_____
6. Does your child have any endocrine problems such as diabetes, thyroid problems, pancreas or other? ☐Yes ☐No
   If yes, explain_____
7. Does your child have any muscular problems such as weakness, paralysis, spasticity, muscular dystrophy? ☐Yes ☐No
   If yes, explain_____
8. Does your child have neurologic problems such as seizures, palsy, developmental delay, stroke, autism, ADHD? If yes, explain_____ ☐Yes ☐No
9. Does your child have any kidney problems such as kidney failure?
   If yes, explain_____ ☐Yes ☐No
10. Does your child have any blood problems such as hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV or transfusions? If yes, explain_____ ☐Yes ☐No
11. Has your child or any blood relatives ever had problems with general anesthesia? ☐Yes ☐No
    If yes, explain_____
12. Please list all serious illnesses or hospitalizations and dates:

    _____
13. Please list all surgical operations and dates:

    _____

I understand that the accuracy of this health history is critical to the safety of general anesthesia. I have carefully answered all questions truthfully and to the best of my knowledge. **Please use the back of this form if more room is needed to complete the health history**.

Signature of Responsible Party_____ Date_____

## For Dental Office Staff Use Only

### Procedure Information

Dental Office Name : _____ Treating Dentist:_____

Date of Service: _____ Length of Treatment: _____

3401 Royal Vista Blvd, Ste A100, Round Rock, TX. 78681
Phone: 512-909-3171 Fax: 512-246-3678
www.iheartsedation.com

# The Health Insurance Portability and Accountability Act (HIPAA)

Patient Name_____ Date of Birth_____

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Administrative Simplification portion of HIPAA required the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

The *Sedadent Anesthesia Services Notice of Privacy Practices* describes Sedadent Anesthesia Services policies in regard to HIPAA. This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully and sign below.

Yes, I've read Sedadent Anesthesia Services' Notice of Privacy Practices

Signature of Patient or Parent/Guardian_____

Print Name_____

Date _____

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# Financial Policy

Since everyone benefits when definitive financial arrangements are agreed upon in advance, we have prepared this material to acquaint you with our financial policy for anesthesia services.

Anesthesia services provided in the office setting considerably lowers the cost of care when compared to care provided in a hospital or outpatient surgical center. Fees can be kept low by utilizing the equipment and facilities your doctor has already provided. The anesthesia fee is based on your doctor's time for the procedure. As such, the time estimate may vary based on surgical complexity or anesthesia preparation time. The anesthesia- billing period is from the time you are seated until the recovery is completed.

Because of the pre-surgical preparation required by Sedadent Anesthesia Services to provide safe, quality care and the scheduling of our case to the exclusion of other offices and patients, a deposit must be paid prior to the scheduling of the case. The deposit will be applied to the total anesthesia charges the day of the procedure. The balance of the anesthesia charges will be due the day the before service is provided.

To confirm anesthesia services for your appointment, a minimum deposit of $300 will need to be sent to our office the day that the appointment is scheduled. If the appointment is in less than 7 days, please call the office and pay the deposit with a credit card. The balance of the fee is due prior to treatment. The fee for anesthesia including all pre-anesthesia evaluations, all drugs, supplies, anesthetic care and recovery is as follows.

**The fee for services lasting less than one and one-half hours (1½hr)_____$1000.**

**The fee for services lasting more than one and one-half hours (1½hr)_____$1300.**

**Arrangements will be made with the doctor for services lasting longer than three (3) hours.**

We accept cash, money orders, MasterCard, Visa, Discover, and American Express and Care Credit.

**All payments should be made payable to: Sedadent Anesthesia Services**

**INSURANCE**

Although we do not accept insurance as direct payment for our services, our office will gladly assist you after treatment is performed with the processing of your insurance form so you may be reimbursed from your insurance provider directly. Recent changes have occurred in Texas laws that have dramatically increased the coverage provided under many health insurance plans for anesthesia for dentistry. However, we still recommend that you check with your carrier before treatment to determine any policy limitation, deductible, or co-payment. We will work with you and your carrier by providing information to ensure that your claim is processed properly.

Should you have any questions regarding our services or financial arrangements, please do not hesitate to contact us

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# Credit Card Deposit/Payment for General Anesthesia

Patient Name:_____

Dentist Office:_____ Date Scheduled:_____

Please indicate the type of card:

- ☐ Visa
- ☐ Mastercard
- ☐ American Express
- ☐ Discover
- ☐ Care Credit

Credit Card #_____

Exp Date_____ Security Code (on back of card) _____

Billing Address_____

Amount

- ☐ Deposit - $300
- ☐ ≤ 90 Minutes - $1000
- ☐ ≥ 90 Minutes - $1300

Deposit is due on date of scheduling. Full amount is due at least one day prior to treatment date. I authorize Sedadent Anesthesia Services to charge the above referenced card for the amount indicated. Any additional balance due after the procedure may be charged as indicated unless other arrangements have been made.

Signature _____

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# PRE - ANESTHESIA INSTRUCTIONS

Drinking and Eating: In order to decrease the risk of complications during anesthesia, it is VERY IMPORTANT that your child does NOT have ANYTHING TO EAT OR DRINK eight (8) hours before your scheduled dental procedure. During anesthesia the muscles above the stomach can relax, releasing stomach contents into the lungs. This can lead to serious complications including death. Your child may have CLEAR LIQUIDS ONLY, up to two (2) hours before the procedure. Examples of clear liquids include water, apple juice, or Gatorade. Consuming food, milk, orange juice or other non-clear liquids within eight (8) hours will be rescheduled.

Clothing: Loose clothing with short sleeves is desirable, as are two-piece outfits, to allow easy monitor placement. Contact lenses must be removed before the appointment. Do not wear fingernail polish the day of appointment. For children, a change of clothing is recommended for unexpected urination. Please use the restroom upon arrival at the dental office.

Change in Health: Please inform the doctor of any change in your child's health prior to your appointment. The development of a cold or fever can increase the risks of anesthesia. Sick patients may be reappointed for safety reasons.

Medication: Please follow your regular schedule of medications unless otherwise directed by the doctor. Medications may be taken with only a small sip of water.

Accompanied by an adult: A responsible adult must accompany all anesthesia patients to and from the appointment. The responsible adult should remain in the office during the appointment unless otherwise authorized by the practitioner. A responsible adult must drive the patient home. (Buses or cabs are unacceptable)

Questions or Concerns: Please expect a call from the doctor the night before the appointment to answer any questions or concerns.

Please contact Sedadent Anesthesia Services if you have any other questions or concerns: **(512) 909-3171**

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