INFORMED CONSENT AND RECORDS RELEASE FOR ANESTHESIA PEDIATRIC

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients apprehensive but to enable them to be better informed concerning their treatment. The choices for anesthesia are: local anesthesia alone, local with intravenous sedation, or general anesthesia. These are administered depending upon each individual patient's unique requirements.
The side effect seen most frequently of any intravenous infusion is phlebitis which occurs only 2-4 percent of the time. Phlebitis is a raised, tender, hardened, inflammatory response at the site of the injection which can have onset from 24-48 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm (100°F) moist heat, yet tenderness and a hard lump may be present up to a year.

I,_____ , hereby authorize and request **Andrew Elmasri, D.D.S.** 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 (from local to general) by any method that is deemed suitable by Dr. Elmasri. It is the understanding of the undersigned that Dr. Elmasri is an independent contractor and consultant and will have full charge of the administration and maintenance of the anesthesia, which is an independent function of the surgery/dentistry. I also understand that Dr. Elmasri has no responsibility for the dentistry to be performed or the diagnosis or treatment planning involved in the dentistry.

I have been informed and understand that occasionally there are complications of the local anesthesia and medications, including but not limited to: pain, hematoma, temporary or permanent numbness of the face, teeth, tongue, lip or gums, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, stroke, and heart attack. I further understand and accept the risk that very rare complications may require hospitalization that could result in death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three, local anesthesia is usually considered to have the least risk and general anesthesia the greatest risk. However, it must be noted that local anesthesia alone may not be appropriate for every patient and every procedure and that local and sedation may be safer than local alone.

Because medication, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can be increased by the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least twenty-four (24) hours or longer until fully recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any major or important decisions until after full recovery from the anesthesia. I understand that those with a history of chemical or alcohol dependency have a possible risk of relapse after anesthesia and should take appropriate precautions and support options.

I have been fully advised of and accept the possible risks and dangers of anesthesia. I acknowledge the receipt of, understand and agree to follow both pre and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and I am satisfied with the information provided to me**. I also request that my physicians release to Dr. Elmasri any information he desires regarding my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my surgery and anesthetic management**. I also authorize Dr. Elmasri to speak with my spouse, parents or children regarding any phase of my treatment.
I have received a copy of instructions and this consent.

Date_____ Patient Name _____

Parent/Guardian Name_____ Parent/Guardian Signature_____

Witness Name_____ Witness Signature_____

Pediatric Health History

PATIENT INFORMATION (CONFIDENTIAL) Today's Date _____

Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Email (optional): _____

Home Phone: _____ Cell Phone _____

Address: _____ City: _____ State: _____ Zip: _____

1. Height: _____ Weight: _____
2. Is your child/teen currently under the care of a physician for a specific condition? _____ Yes No
3. Date of last physical exam/checkup? _____
4. Date of last cold, cough or fever? _____
5. Physician: _____ Phone Number: _____
6. Describe your child/teen's activity level: Always tired Frequently tired Active Very active
7. Has there been any change in your child/teen's health in the last year? _____ Yes No
8. Has your child/teen had any hospitalizations or surgeries? _____ Yes No
   a. If yes, when and why _____
9. Does your child/teen have any cardiac conditions? _____ Yes No
   a. If yes, circle- arrhythmia's, congenital heart disease, murmurs
      Other _____
10. Does your child/teen have pulmonary disease or symptoms? _____ Yes No
    a. If yes, circle- asthma, bronchitis, cystic fibrosis, frequent colds/flu, persistent cough, wheezing
       Other _____
11. Has your child/teen ever been diagnosed with sleep apnea? _____ Yes No
12. Has your child/teen been diagnosed or ever had any of the following medical problems?
    a. Arthritis
    b. Autism
    c. Bleeding Problems / Bruise easily
    d. Blood disorder
    e. Cancer
    f. Cerebral palsy
    g. Diabetes
    h. Down's syndrome
    i. Fainting episodes
    j. Hepatitis / Liver problems
    k. Kidney Problems
    l. Muscle weakness
    m. Seizures / Epilepsy
    n. Other _____

12. Please list all medications that your child/teen is currently taking: _____
    _____
13. Does your child/teen have allergies to medication or food? _____ Yes No
    a. If yes, list all allergies _____
14. Have you or a close relative ever had a bad reaction to any anesthetic drug? _____ Yes No
15. Has your child/teen had a previous general anesthetic? _____ Yes No
    a. If yes, were there any complications? _____ Yes No

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Andrew Elmasri of any changes in my child/teen's medical status at the earliest possible time.

_____

Signature of Parent/Guardian Date

_____

Reviewed by: Andrew Elmasri, DDS Date

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Patient Name :_____Contact Number :_____

Date of Procedure :_____ E-mail :_____

Your dentist has estimated treatment time to be: _____ hour(s) _____ minutes

Total Anesthesia Time = Dentist's treatment time PLUS 60 Minutes (30 minutes for induction and 30 minutes for recovery)

Anesthesia Fees are: $600 for the first hour & $150 for each additional 15 minutes

As the anesthesia fee estimate is based upon the surgeon's estimated time, the actual fee will vary with the surgical complexity and with the patient's response to the drugs and surgery. Anesthesia time begins when you are seated/anesthesia begins and ends when you are fully recovered and discharged to a responsible adult and are charged in 15 minute increments. Therefore the anesthesia Estimate is typically about an hour longer than the surgical time.

To confirm anesthesia services for your appointment, a deposit of $600 for 60 minutes of anesthesia time is due. The fee for anesthesia includes all pre-anesthesia evaluations, consultations with physicians if necessary, all drugs, supplies, and 30 minutes of anesthesia time. If a refund for any unused time is necessary, we will issue a refund. Any additional fee for additional time will be due at time of service.

We accept cash, checks, MasterCard, Visa, American Express, and Discover ***(Please Circle One)***

Patient/Guardian Name_____ Patient/Guardian Signature_____

Cardholder Name:_____ ZIP:_____ Exp. Date:_____

Credit Card Number:_____ Security Code on CC:_____

I agree to the attached Remittance of Fees, Cancellations, and Rescheduling Policies.

Signature of Cardholder/Financially Responsible Party:_____
Date:_____

Please sign/date even if enclosing a check

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Insurance Information

Our office will mail you an *ADA approved Dental Claim Form (with our sections filled out)* for you to review, complete and send directly to your carrier after the procedure, upon your request. If t is important that reimbursement for the anesthesia fee by dental or medical insurance programs not be assumed as you may be over your yearly maximum benefits. Some insurance policies do not pay for anesthesia services when rendered for procedures other than exodontia (removal of teeth). Please check with your insurance company representative if you have questions regarding your coverage. Medical insurance and Medicare do not cover dental expenses and will not process dental or medical claims for your dental procedures.

Cancellations and Rescheduling

Your forms and remittance must be received at least 2 weeks prior to your treatment date. After that time, we will assume you are not ready for this scheduled appointment and your time may be released to accommodate another patient. We realize that life can be hectic so it is very important that you carefully review your vacation, work and family calendars before confirming your appointment by signing our forms. Cancellations or rescheduling within 72 business hours of the treatment date will incur a 100% charge of the estimated anesthesia time. Cancellations or reschedules must be made with our office or will be charged as a cancellation on the day of the procedure. Failing to follow the dental or anesthetic pre-operative instructions resulting in the canceling of the appointment (eating, not taking a prescribed antibiotic, etc) will incur a 100% charge. Illness requiring medical intervention will not incur a charge.

I, _____, have read, understand, and agree to the above ESTIMATE of fees, terms, and conditions.

Signature of Patient, Parent or Legal Guardian: _____ Date:_____

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Pre-Anesthesia Instructions

Eating / Drinking
Failure to strictly follow these instructions could result in aspiration and may be fatal. For anesthesia, it is of utmost importance that patients have an empty stomach.

No food of any kind for 8 (eight) hours prior to the appointment.

Clear liquids i.e. water, apple juice, Gatorade, may be taken up to 2 (two) hours prior to the appointment.

Clothing
Please wear a short sleeve loose shirt. Patients should bring a blanket. For children who do not wear a diaper or pull up, please bring an extra set of clothes. Do not wear makeup, nail polish, or fake eyelashes. Contact lenses must be removed before anesthesia. Please do not bring anything valuable or wear any jewelry.

Change in health or medications
A change in health, especially the development of a cold, cough, or fever is EXTREMELY important. Please notify Dr. Elmasri if there is any change in your health. Your appointment may need to be rescheduled.

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 sports drinks, clear juice and soda as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Suggestions include 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 or Tylenol Elixir for children 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 24 hours, or if you have other serious concerns following anesthesia, please contact: Dr. Elmasri at (949) 288-3401. In the event of a serious medical emergency, please call 911.

I, _____, have read and understand the given instructions.

_____ _____

Signature of Patient/Parent or Legal Guardian: Date:

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TRANSPORTATION INFORMATION

PATIENT'S NAME:_____

As you know, a responsible adult must drive you to and from your dental appointment and a responsible adult must stay with you overnight. Advise your driver that they are expected to escort you to the office and wait for about 30 minutes. If you can arrange to have your ride home be the same person who spends the night with you we can give them your post surgical instructions.
Unless your ride waits for you in the dental office during your entire appointment, we will need the following information and an alternate driver.

We realize that it is extremely unlikely that your ride will fail to return for you, but about twice a year, accidents, car trouble, and illness force us to contact the alternate driver. Without an alternate driver, those patients would have had to have been admitted to a hospital overnight. Therefore it is in everyone's best interest that you complete the following:

Patient/Guardian Signature:_____

Expected Driver's Name: _____Phone:_____

Time (in minutes) needed by driver to return to dental office:_____

Alternate Driver's Name:_____ Phone:_____

Phone # where you may be reached after your appointment:_____

Phone # of your pharmacy:_____

My ride will be present throughout the duration of the procedure (Circle): Y N