



Phone: 210-460-0271 Fax: 866-525-9008
FrontOffice.DAG@gmail.com

Pediatric / Teen Health Questionnaire

Patient Name: _____ Birth date: _____ Weight: _____ lbs

Dentist Name: _____ Appointment Date: _____ Age _____ Sex _____

Parent Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Mother/Cell: _____ Father/Cell: _____

E-mail address: _____

Does your child have, or have they ever had, any of the following? (If yes, check the box)

- | | |
|--|--|
| <input type="checkbox"/> Asthma, Reactive Airway, Wheezing, Breathing | <input type="checkbox"/> Congenital Heart Defect, Damaged or Abnormal Heart Valve |
| <input type="checkbox"/> Pneumonia, Bronchitis, Chronic Cough | <input type="checkbox"/> Swallowing Difficulties, Aspiration or Choking episodes |
| <input type="checkbox"/> Head & Neck injury or trauma (Brain or Spinal Injury) | <input type="checkbox"/> Irregular Heart Beat, Palpitations, Arrhythmia |
| <input type="checkbox"/> Complications at birth | <input type="checkbox"/> Genetic Disorder, Congenital Abnormalities, Syndrome |
| <input type="checkbox"/> Croup (barking cough), Stridor | <input type="checkbox"/> Heart Disease, High or Low Blood Pressure |
| <input type="checkbox"/> Previous general anesthesia or surgery | <input type="checkbox"/> Seizure or Epilepsy/ Convulsions (other brain disorders) |
| <input type="checkbox"/> Respiratory Problems (Tuberculosis, Cystic Fibrosis) | <input type="checkbox"/> Rheumatic Fever /Scarlet Fever |
| <input type="checkbox"/> Problems during or after anesthesia | <input type="checkbox"/> Kidney Disease, Bladder Disorders |
| <input type="checkbox"/> Sleep Apnea (stops breathing while asleep) or Nighttime Snoring | <input type="checkbox"/> Bleeding, Nose Bleeding, Easy Bruising, Clotting Problems |
| <input type="checkbox"/> Family relatives having problems during or after anesthesia | <input type="checkbox"/> Liver Disease (Jaundice or Hepatitis, other) |
| <input type="checkbox"/> Breathing through mouth due to nasal congestion | <input type="checkbox"/> Anemia (Including Sickle Cell Anemia) |
| <input type="checkbox"/> Cancer, Tumor, Chemotherapy, Radiation therapy | <input type="checkbox"/> Diabetes, Nutritional Disorders |
| <input type="checkbox"/> Shortness of breath/fatigue/dizziness when running | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Thyroid Disease, Adrenal gland problems, Hormone Therapy | <input type="checkbox"/> Organ transplant/ Bleeding disorder |
| <input type="checkbox"/> Fainting spells or Blackouts | <input type="checkbox"/> Auto-Immune disease/suppressed immune system. |
| <input type="checkbox"/> Hiatal Hernia, Heartburn, Acid Reflux, Indigestion | <input type="checkbox"/> ADD or ADHD, Autism (circle one or more) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Muscle Disease (Muscular Dystrophy, others) |
| <input type="checkbox"/> Stomach/intestinal problems (ulcers/bleeding, other) | <input type="checkbox"/> HIV/AIDS |

If Yes, Please Explain: _____

- Any cold, cough, fever, flu or sore throat **within the last 4 weeks**? (please circle all that apply) Yes No

If Yes, Please Explain: _____

**** any child with a recent cold or upper respiratory infection within the past four weeks is at a TEN FOLD risk of airway complications during sedation. It is EXTREMELY important that you inform our office if your child has recently had a possible cold.**

- Past hospitalizations/surgeries or emergency room visit? Reason? _____ Yes No

If Yes, Please Explain: _____

- Was the child born premature? How many weeks at birth? _____ Yes No

- Does your child have ANY disease, condition or problem not mentioned so far? Yes No

If Yes, Please Explain: _____

- Does the patient take any medication regularly and/or as needed (including over the counter?) Yes No

○ Please list medications: _____

- Are there any behavioral/emotional/cultural/spiritual concerns that we need to be aware of? Yes No

If Yes, Please Explain: _____

- List all allergies: (latex, soy, egg, sulfa, aspirin, Ibuprofen, codeine, antibiotics, local anesthetics etc.)

○ _____

- What happens? Rash/hives Breathing problems/wheezing Swelling Itching

○ Other: _____

I understand that withholding any information about my child's health could seriously jeopardize his/her safety during anesthesia. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge.

Name: _____
(Parent or Legal Guardian)

Signature: _____

Date: _____



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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 either 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.

I have been informed and understand that on rare occasions anesthesia related complications include, but are 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 anesthesia vary. Of the three choices of anesthesia, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk.

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 responsibility for informing the 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.

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.

I hereby authorize and request the attending anesthesiologist from The Dental Anesthesia Group, 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.

I have been fully advised and completely understand the alternatives to conscious sedation and general anesthesia. I accept the possible risks, side effects, 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. I also understood that the anesthesia services are completely independent from the operating dentist's procedure.

I have read and understand the consent for anesthesia. I have had the opportunity to have all my questions answered regarding the risks, benefits and alternatives of anesthesia.

Patient Name _____ Date _____

Parent/Guardian's Name _____ Relationship to Patient _____

Signature _____ Witness _____



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Financial Agreement for Anesthesia Services

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 30 Minutes (15 minutes for induction and 15 minutes for recovery)

Anesthesia Fees are: \$900 for First Hour and a Half & \$150 for each additional 15 Minutes
(Pediatrics – up to age 12)

The costs of anesthesia are considerably lower in your dentist's office when compared to the cost of anesthesia services in a hospital setting. The anesthesia fee estimate is based upon the dentist's estimated operating time. The time estimated may vary based on surgical complexity or anesthesia preparatory time.

Because of the pre-surgical preparation required by our group to provide safe, quality care, and the scheduling of your case to the exclusion of other offices and patients, a deposit must be paid to secure the appointment date.

To confirm anesthesia services for your appointment, the full amount for services (based upon estimated treatment time) will be collected upfront at the time of booking. For pediatric patients, a deposit of \$850 (for 1.5 hours of anesthesia time) is due. The fee for anesthesia includes all pre-anesthesia evaluations, consultations with physicians if necessary, all drugs, supplies, and the time 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 as payment:

- CASH - Eligible for a 5% Discount
- Checks
- Credit Card - payments are subject to a 3% fee
(additional time charges are not subject to this fee)

* Full payment is due on the day of the appointment; all payments not paid in full by 2 weeks after treatment day is subject to a penalty of \$10 per day until complete payment is fulfilled unless a payment plan is prearranged.

Insurance

Although we do not accept insurance as direct payment for our services, our office will gladly provide receipts to attach to your insurance forms the day of surgery. I hereby authorize my doctor to release any information requested by my insurance carrier.

This AGREEMENT made by and between the undersigned PATIENT/PARENT/GUARDIAN and The Dental Anesthesia Group

Patient/Parent/Guardian shall be in default of this Agreement if the Patient/Parent/Guardian fails to pay, in full the cost of services rendered under this Agreement on the date of treatment. If the Patient/Parent/Guardian is in default of this Agreement, any and all unpaid portions of fees owed shall bear interest at the maximum rate allowed by law, compounded monthly, until collected from the date of treatment. **Any deposits will not be refundable and forfeited if not given 48 hours notice prior to cancellation.**

In the event the Patient/Parent/Guardian fails and/or refuses to make payment for services rendered under this Agreement and is in default of this Agreement, the Patient/Parent/Guardian shall be responsible for all ACTUAL costs, attorney fees and interest incurred by The Dental Anesthesia Group in the collection of the debt accumulated under this Agreement.

Patient/Parent/Guardian hereby consents and agrees that if the Patient/Parent/Guardian is in default of the payments required herein, The Dental Anesthesia Group may file a legal claim in Bexar County, Texas, rather than the County in which the Patient/Parent/Guardian is located, and further that proper venue in all disputes between the parties hereto shall be in Bexar County, Texas. This Agreement will be governed by the laws of the State of Texas. This Agreement constitutes the entire agreement by the parties and supersedes any written or oral agreement of the parties prior to the date hereof. Amendments to this Agreement may only be made in writing and signed by the parties.

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

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

Full Name: _____



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Pre-Anesthesia Instructions

Eating / Drinking

For anesthesia, it is of utmost importance that patients have nothing to eat or drink prior to the scheduled appointment. Failure to strictly follow these instructions could result in aspiration and may be fatal.

No food or drink after **midnight** the day prior to surgery. Medications should be taken with sips of water.

Clothing

Please wear a short sleeve loose shirt and comfortable pants. Children should be in a T-shirt and pajama pants. 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 our office 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.

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 24 hours, or if you have other serious concerns following anesthesia, please contact Dr. Ayyash 817-405-9248. 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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Credit Card Authorization Form

**** Credit Card information is required for appointment confirmation regardless of method of payment****

Thank you for deciding to use The Dental Anesthesia Group for your dental anesthesia needs. As an added convenience for our patients we have provided the option of taking care of your financial arrangements with scheduled charges to your credit card.

By signing this form I, _____, am authorizing The Dental Anesthesia Group to charge my credit card identified below on the date(s) stated below. Should my credit card payment be rejected or denied by the credit card company for any reason, I understand that I am still obligated to pay The Dental Anesthesia Group the amounts owed on the designated date(s) listed below and hereby agree to make a full payment.

Payment Amount: \$ _____ + Additional anesthesia time balance (To Be Determined)

Payment Due Date: _____

Credit Card Number: _____ - _____ - _____ - _____

Security Code: _____

Expiration Date: _____

Name on Credit Card: _____

Billing Address: _____

Billing Zip Code: _____

Billing Phone Number: _____

Signature of Cardholder: _____

Email: _____

Date: _____