Patient Registration

Special Anesthesia Services
727 N. Baltimore Ave.
Derby, KS 67037
Ph: (316) 788-5939
Fx: (316) 788-5945
Email: office@sleepinsafety.com
Web address: www.sleepinsafety.com

Please fill in this registration sheet COMPLETELY and submit it to our office as soon as possible prior to the scheduled appointment. Thank you.

Please circle the correct unit of measurement

Today's Date: ____________ Pt. Height ________ Weight ________ kg / lbs

Dentist/Doctor: ____________ Appt Date: ________ Time: ______ Length: ______

Patient's Name: ______________________ DOB: ____________

Patient's Age: ______ ☐ Male ☐ Female

Parent/Guardian: ______________________________

Patient's Contact Numbers: (   ) ________ (   ) ________ (   ) ________

Patient's Address: ______________________________

City: ________________ State: ________ Zipcode: ________

E-mail Address: ______________________________

Primary MEDICAL Insurance Information: *We do NOT file with dental insurances.*

Insurance Company: ______________________________

Cardholder Name: ____________ DOB: ________ Employer ________

Insurance ID#: ____________________ Group#: ____________

Secondary Medical Insurance Information:

Insurance Company: ______________________________

Cardholder Name: ____________ DOB: ________ Employer ________

Insurance ID#: ____________________ Group#: ____________

SAS Adult Medical History

Date_______________

Patient's Full Name ____
DOB____/____/______ Age ___________
Gender: □ M □ F Height _______ Weight: _______ lb or kg (Please circle)

Name/address/phone of primary physician ____
Date of last appt ________________
Name/address/phone of medical specialists: ____

1) Are you being treated by a physician at this time? Reason ______________________________ □ Yes □ No
2) Have you been ill in the past 6 weeks? Describe ______________________________ □ Yes □ No
3) Are you taking any medication (prescription or over-the-counter), vitamins, or dietary supplements?... □ Yes □ No
   List name, dose, frequency, and date started: ______________________________(use notes section below if needed)
4) Have you ever been hospitalized, had surgery or significant injury, or been treated in an ER?................ □ Yes □ No
   List date and describe: ______________________________(use notes section below if needed)
5) Have you, or family members, ever had a reaction to or problem with an anesthetic? .... □ Yes □ No
   Describe: ______________________________
6) Have you ever had a reaction or allergy to an antibiotic, sedative, or other medication? .... □ Yes □ No
   List ______________________________
7) Are you allergic to latex or anything else, such as metals, acrylic, dyes, or foods? Soy allergy? .... □ Yes □ No
   List ______________________________

Please mark YES if you have a history of the following conditions. For each "Yes", provide details at the end of this form.
Mark NO after each line if the conditions do not apply to you.

8) Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions . . □ Yes □ No
9) Disorders, learning problems/delays, or intellectual disability .... □ Yes □ No

10) Sinusitis, chronic adenoid/tonsil infections .... □ Yes □ No
11) Sleep apnea/snoring, mouth breathing, excessive gagging, or frequent bloody noses............................. □ Yes □ No

12) Heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease .... □ Yes □ No
13) Irregular heart beat, high blood pressure, or fast heart beat .... □ Yes □ No
14) Shortness of breath, chest pain, dyspnea on exertion, coronary artery disease or stents, stroke,
    pacemaker/defibrillator? .... □ Yes □ No

15) Asthma, reactive airway disease, wheezing, or breathing problems .... □ Yes □ No
16) Cystic fibrosis .... □ Yes □ No
17) Frequent colds or coughs, pneumonia, or bronchitis .... □ Yes □ No
18) Do you smoke, vape, or use any other tobacco products? How much per week .... □ Yes □ No

19) Jaundice, hepatitis, or liver problems .... □ Yes □ No
20) Do you drink alcohol? If so, how much per week? .... □ Yes □ No
21) Do you use recreational drugs? (what type? how often?) .... □ Yes □ No
22) Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems .... □ Yes □ No
23) Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions .... □ Yes □ No
24) Prolonged diarrhea, unintentional weight loss, concerns with weight, eating disorder, nausea or
    vomiting .... □ Yes □ No

______________________________ ______________________________
Date Completed Name/Signature of Person completing this form

______________________________ ______________________________
Relationship to Patient Printed Name of Person completing this form

25) Bladder or kidney problems .... ☐ Yes ☐ No

26) Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems .... ☐ Yes ☐ No

27) Rash/hives, eczema, or skin problems .... ☐ Yes ☐ No

28) Impaired vision, hearing, or speech .... ☐ Yes ☐ No
29) Cerebral palsy, brain injury, epilepsy, or convulsions/seizures .... ☐ Yes ☐ No
30) Autism/autism spectrum disorder, Down Syndrome, MR, or other diagnoses .... ☐ Yes ☐ No
31) Recurrent or frequent headaches/migraines, fainting, or dizziness .... ☐ Yes ☐ No
32) Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous .... ☐ Yes ☐ No
33) Do you have any implanted devices? .... ☐ Yes ☐ No

34) Attention deficit/hyperactivity disorder (ADD/ADHD) .... ☐ Yes ☐ No
35) Behavioral, emotional, communication, or psychiatric problems/treatment .... ☐ Yes ☐ No
36) Abuse (physical, psychological, emotional, or sexual) or neglect .... ☐ Yes ☐ No

37) Diabetes, hyperglycemia, or hypoglycemia .... ☐ Yes ☐ No
38) Hormonal problems .... ☐ Yes ☐ No
39) Thyroid, pituitary problems, or adrenal gland problems .... ☐ Yes ☐ No

40) Anemia, sickle cell disease/trait, or blood disorder .... ☐ Yes ☐ No
41) Hemophilia, bruising easily, or excessive bleeding .... ☐ Yes ☐ No
42) Transfusions or receiving blood products .... ☐ Yes ☐ No
43) Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow/organ transplant ☐ Yes ☐ No

44) Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS) .... ☐ Yes ☐ No

PROVIDE DETAILS HERE: ____

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Is there any other significant medical history **pertaining to you or your family** that we should know? .... ☐ Yes ☐ No

Describe: ____

____

____

______________________ Date Completed

______________________ Name/Signature of Person completing this form

______________________ Relationship to Patient

______________________ Printed Name of Person completing this form

SAS Patient Instruction Sheet

You will be receiving intravenous medications during your operative procedure. It is therefore very important that you adhere to the following instructions. If there are any questions, please don't hesitate to call for further instructions: (316) 788-5939.

It is essential for your safety that you strictly adhere to the following policies. Failure to do so will result in cancellation of surgery and can put you in danger of severe lung injury or death.

1) No food for **eight (8) hours** prior to your arrival at the office:
   - No solid food of any kind
   - No milk, cheese, yogurt, or ice cream
   - No candy, including vitamins
   - No chewing gum or mints
   - No products containing protein and/or milk products, even if they appear clear
   - No orange juice
2) **Clear** liquids are allowed up to **three (3) hours** prior to arrival time. Approved liquids are:
   - Water
   - Gatorade or clear sports drinks
   - Sprite
   - Jello with NO fruit or cream
   - Black coffee
3) Do NOT brush teeth, as you may swallow water and/or toothpaste, resulting in cancellation.
4) Wear comfortable clothing, preferably a shirt or blouse with short sleeves. It is suggested you wear an adult *Depends*/brief or bring a change of clothing as a precaution for possible bladder leakage, as sometimes occurs with sedation.
5) If you have a prescription for breathing treatments, please bring this inhaler the day of the procedure.
6) Arrange for transportation from surgeon's office to your home.
7) After your surgery, wait until the next day before engaging in any activity in which a decrease in alertness, judgement, or coordination could cause a problem (including driving).
8) After surgery, you may take pain medication as directed by the surgeon. However, avoid alcohol post-operatively for 24 hours.
9) Arrange for adult assistance for at least 12 hours after surgery.

I have read the above instructions, they are clear to me, and I agree to comply:

______________________________ ____________________________________

Patient Name Signature of Patient or Responsible Party

Please fax or send completed forms to our office as soon as possible prior to the date of service. Your cooperation will enhance the safety of this procedure and is appreciated. Fax to (316) 788-5945.

SAS Deposit Information

Welcome! Following is some general information regarding sedation and insurance policies. Most insurances will not cover sedation services for individuals over the age of five. Special Anesthesia Services requires a 25% deposit from all patients. This is typically due three (3) weeks in advance, however, many times a pediatric patient is not scheduled three weeks in advance. In those cases, a deposit is due as soon as possible.

The patient/parent/guardian understands, acknowledges and agrees that if he/she fails to appear for the sedation dental appointment, violates the food and drink restrictions, does not cancel the appointment in a timely manner or does not complete the required paperwork in a timely manner, the non-refundable deposit **will be forfeited.** Should the patient not be medically cleared for office-based anesthesia, the deposit will be returned. Extenuating circumstances will be considered at the discretion of Special Anesthesia Services.

Special Anesthesia Services agrees, in consideration of payment of the non-refundable deposit, to subtract the deposit from the total amount due at the time of service, assuming compliance with the second paragraph. The deposit will be forfeited otherwise.

Please sign and return with the completed paperwork immediately. For the deposit you may include a check or call us with the credit card information for payment via telephone. Thank you.

Length of Time for appointment	Standard Fees	Deposit Amount
30 minutes	$483	$120
45 minutes	$552	$140
60 minutes	$621	$155
1 hour 15 minutes	$690	$175
1 hour 30 minutes	$759	$190
1 hour 45 minutes	$828	$210
2 hours	$897	$225

Length of Time for appointment	Standard Fees	Deposit Amount
2 hours 30 minutes	$1035	$260
2 hours 45 minutes	$1104	$275
3 hours	$1173	$295
3 hours 15 minutes	$1242	$310
3 hours 30 minutes	$1311	$330
3 hours 45 minutes	$1380	$345
4 hours	$1449	$360

Special Anesthesia Representative Signature

Patient Signature

Special Anesthesia Representative Print Name

Patient Print Name

Date

Date