Special Anesthesia Services
727 N. Baltimore
Derby, KS 67037
Phone: 316-788-5939
Fax: 316-788-5945
Email: office@sleepinsafety.com
Website: www.sleepinsafety.com

Pediatric Patient Registration

Please fill in this registration sheet COMPLETELY!

Today's Date: _____ **Pt Height**: _____ **Pt Weight**: _____ □ Kg □ lbs

Dentist's Name: _____ **Appt Date**: _____ **Appt Time**: _____ **Length**:_____

Patient's Name: _____ **Patient's DOB**: _____

Patient's Age: _____ **Patient's Sex**: *please circle* Male Female

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Patient's Contact Information: *please fill in all applicable contacts that you are giving our office permission to speak with regarding this patient's upcoming dental sedation appointment.*

Relationship to the Patient	Name	Phone Number with Area Code
Biological Father		
Biological Mother		
Adoptive Father		
Adoptive Mother		
Foster Father		
Foster Mother		
Guardian		
Grandparent		
Other:		

Primary Medical Insurance: We DO NOT file with any Dental Insurances!

Insurance Name: _____ **Employer**: _____

Cardholder's Name: _____ **Cardholder's DOB**: _____

ID #:_____ **Group #**: _____

Secondary Medical Insurance

Insurance Name: _____ **Employer**: _____

Cardholder's Name: _____ **Cardholder's DOB**: _____

ID #:_____ **Group #**: _____

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Dental Insurance Information

Is the patient's dental insurance through BCBS of Kansas? □ Yes □ No

Medical Insurance Cards

Please submit a copy of the patient's medical insurance cards. Please include the front and back of each card and all medical insurances that the patient has.

Text: sas444@icloud.com

Email: office@sleepinsafety.com.

Financial/Insurance Information

Special Anesthesia Services will contact the patient/guardian regarding sedation fees for upcoming dental procedure. Our office does require a 25% non-refundable deposit be paid, 3 weeks before the scheduled sedation procedure. Our office is able to take all major credit cards (except American Express), Care Credit, or cash. Please contact our office with any questions or concerns.

Medical Clearance Requirements

Special Anesthesia Services requires medical clearance be on file with our office before the scheduled sedation appointment. This will include the patient's Primary Care Physician (PCP) and any specialists that the patient sees. Please make sure to complete the information on the next page with all doctors and specialists' information. Our office will request the needed records and signatures from the listed doctors.

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Pediatric Medical History

Patient's Name: _____ **Patient's DOB**: _____

Patient's Age: _____ **Patient's Sex**: please circle Male Female

Pt Height: _____ **Pt Weight**: _____ □ Kg □ lbs

Name of Patient's Primary Care Physician: _____

Primary care Physician's Phone Number: _____

Does the Patient see any Specialty Doctors: *please complete if yes* □ Yes □ No

Specialist Type	Specialist Name	Phone Number/Location
Cardiologist		
Neurologist		
Pulmonologist		
Gastroenterologist		
Allergist		
Nephrologist		
Urologist		
Plastic Surgeon		
Other:		

If your answer is yes to any of the following questions, please describe in the box given.

***Is your child being treated by a physician at this time: □ Yes □ No

*Has your child been ill in the last 6 weeks? Please describe: □ Yes □ No

_____

*Is your child taking any medications? Please list name and dosage: □ Yes □ No

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*Has your child ever been hospitalized, had surgery, or been treated in the ER? □ Yes □ No _____

*Has your child or family members ever had a reaction/problem with an anesthetic? □ Yes □ No

_____

*Has your child ever had a reaction or allergy to an antibiotic, steroids, metals, acrylic, dyes, foods, latex, or any other medication allergies? □ Yes □ No _____

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Please check the box next to all conditions that your child currently has or has had in the past. Please describe all checked boxes in detail at the end of this form.

- □ Sinusitis
- □ Chronic Tonsil/Adenoid infections
- □ Sleep Apnea
- □ Snoring/Mouth Breathing
- □ Excessive Gagging
- □ Frequent Bloody Noses
- □ Congenital Heart Defect/Disease
- □ Heart Murmur
- □ Rheumatic Fever/Heart Disease
- □ Irregular Heart Beat
- □ High Blood Pressure
- □ Asthma/Reactive Airway Disease
- □ Wheezing/Breathing Problems
- □ Cystic Fibrosis
- □ Frequent Coughs or Colds
- □ Pneumonia/Bronchitis
- □ Exposure to Tobacco Smoke
- □ Jaundice/Hepatitis/Liver Problems
- □ Acid Reflux (GERD)
- □ Stomach Ulcers/Intestinal Problems
- □ Constipation
- □ Lactose Intolerance
- □ Food Allergies
- □ Nutritional Deficiencies
- □ Dietary Restrictions
- □ Prolonged Diarrhea
- □ Unintentional Weight Loss
- □ Concerns with Weight
- □ Eating Disorder
- □ Bladder/Kidney Problems
- □ Arthritis/Scoliosis
- □ Limited use of Arm or Legs
- □ Muscle, Bone, or Joint Issues
- □ Rash, Hives, Eczema, or Skin Issues
- □ Impaired Vision, Hearing, or Speech
- □ Scarlet Fever/Cytomegalovirus (CMV)
- □ Developmental Disorders
- □ Learning Problems/Delays
- □ Intellectual Disability
- □ Cerebral Palsy
- □ Traumatic Brain Injury
- □ Epilepsy, Seizures, or Convulsions
- □ Autism Spectrum Disorder
- □ Headaches or Migraines
- □ Fainting/Dizziness
- □ Hydrocephaly
- □ Placement of a Shunt
- □ ADD/ADHD
- □ Behavioral, emotional, communication problems/treatment
- □ Abuse or Neglect
- □ Diabetes/Hyperglycemia/Hypoglycemia
- □ Precocious Puberty
- □ Hormonal Problems
- □ Thyroid/Pituitary Disorder
- □ Anemia
- □ Sickle Cell Disease/Trait
- □ Blood Disorder
- □ Hemophilia
- □ Easily Bruising
- □ Excessive Bleeding
- □ Blood Transfusions or blood products
- □ Cancer/Tumor/Malignancy
- □ Chemotherapy/Radiation
- □ Bone Marrow or Organ Transplant
- □ Mononucleosis (Mono)
- □ Tuberculosis (TB)
- □ MRSA
- □ STD or HIV/AIDS

- □ **No Medical History**

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Please provide details below to all boxes that were marked yes on the previous page.

_____

_____

_____

_____

_____

_____

_____

Prematurity/NICU Stay: Was the patient born premature? □ Yes □ No

Did the patient have be admitted to the NICU? □ Yes □ No

Was the patient ever intubated on the ventilator or on CPAP? □ Yes □ No

Did the patient have any complications during or after birth? □ Yes □ No

Females age 12-18: The medications that are used during IV Sedation have the potential to cause birth defects in an unborn fetus. Is there any chance that the patient could be pregnant?

□ Yes □ No

Is there any significant maternal or paternal medical history? □ Yes □ No

_____

_____

Is there any other significant medical history not included above? □ Yes □ No

_____

_____

_____

Date Completed _____

Signature of Person completing this form _____

Printed Name of Person completing this form _____

Relationship to the patient _____

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Pediatric Instruction Sheet

Your child will be receiving IV medications during his/her operative dental procedure. It is therefore very important that you adhere to the following instructions. If there are any questions, please do not hesitate to call for further instructions: 316-788-5939. It is essential for your child's safety that you strictly adhere to the following policies. Failure to do so, will result in cancellation of the operative procedure and can put your child in danger of severe lung injury or death.

1. **No food for 8 hours prior to your arrival time:**
    a. No solid food of any kind, milk, cheese, yogurt, ice cream, juice, or broth
    b. No candy, gum, mints, or vitamins
    c. No products containing protein or milk products, even if they appear clear
2. **Clear liquids are allowed up to 3 hours prior to your arrival time. Approved liquids are:**
    a. Water, Sprite/7-up/Sierra Mist or Gatorade of any color or flavor
    b. Plain Jello with NO added fruit, no vegetables, and no whipped cream
3. **Nothing is to go in the patient's mouth in the 3-hour window directly before his/her procedure.**
    a. No gum, candy, mints, vitamins, or sips of water
4. Do NOT brush the child's teeth on the morning of the appointment, the child may swallow water or toothpaste and this will result in cancellation.
5. Do NOT send your child to school, daycare, or babysitter on the day of the appointment. Children must be monitored by a parent or guardian at all times prior to appointment to verify adherence to above polices. Failure to do so, will result in cancellation of the appointment.
6. If your child has an inhaler or nebulizer, please bring his/her medication with you on the day of the procedure
7. Dress the child in comfortable clothing, preferably a short sleeve shirt. Younger child will occasionally become relaxed enough to lose bladder control. **You may want to consider a diaper, pull up, or a change of clothes just as a precaution.**
8. Children require extra care during transportation home from their appointment. **It is high recommended that two adults accompany the child so the driver do not have to the attend the patient in transit home.**
9. After your child's dental surgery, wait until the next day before allowing him/her to engage in any activity which a decrease in alertness, judgement, or coordinator could cause a problem.
10. After surgery, your child may take pain medication as directed by the surgeon.
11. Please bring appropriate guardianship paperwork, if necessary. If the child is in foster care, a copy of the Consent to Medical Care form and Placement Agreement will be required.

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

Date Completed _____

Signature of Person completing this form _____

Printed Name of Person completing this form _____

Relationship to the patient _____

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SAS Deposit/Insurance Form

Special Anesthesia Services requires a 25% non-refundable deposit from all patients. This deposit is due 3 weeks prior to the scheduled appointment, however, many times a patient is not scheduled 3 weeks in advance. In that case, a deposit is due as soon as possible before the scheduled appointment. Deposit amount is subtracted from the total sedation fee. Deposits are considered non-refundable in the instance of a cancellation within 5 business days, no call/no show on the morning of the appointment, and NPO violation on the morning of the appointment. If the patient is not cleared for medical reasons, the deposit will be returned.

Special Anesthesia Services is contracted with multiple medical insurance companies in the state of Kansas. All medical insurances are unique and provide different coverage for sedation procedures. Some insurances have coverage that is dependent on the remaining deductible/stop loss amounts and co-insurance percentages, while other insurance plans have no coverage at all. SAS will file to insurance companies that we are participating providers with. If SAS is filing to the patient's medical insurance, there is still a possibility of fees being due for the upcoming procedure. If SAS is non-participating provider with the patient's medical insurance, no claim will be filed and sedation fees will be due in full at the time of service.

Special Anesthesia Services is unable to bill any dental insurances

Estimates for sedation fees are based off of length of time from the Referring Provider's office. Sedation fees are based off of time and will increase or decrease, depending on how long the patient is sedated. Once the sedation paperwork is completed, our office will give you a call after verifying your insurance coverage, and will let you know the estimate for the upcoming procedure.

All sedation fees are due in full at the time of service, payment plans are available through Care Credit

Special Anesthesia Services is a contracted provider with Care Credit. If you are interested in more information about Care Credit, please visit their website at www.carecredit.com to apply. If you are using Care Credit for the upcoming sedation appointment, your transaction may qualify for 6 months interest free financing. Please speak with one of the office staff members at SAS for more information.

Our office is able to accept all major cards (except American Express), Care Credit, cashier's checks, money orders, or cash. *No personal checks will be accepted.*

Special Anesthesia Services is not a party included in divorce agreements. Accompanying adult with a minor patient will be responsible for the fees for sedation services.

I understand and have read the above deposit/financial information for the upcoming sedation procedure with Special Anesthesia Services.

Date Completed: _____

Signature of Person completing this form: _____

Printed Name of Person completing this form: _____

Relationship to the patient: _____

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Consent to Obtain Medical Records

A patient's medical history includes a list of past medical diagnosis, illnesses, surgeries, hospitalizations, and medications that your healthcare providers have on file for you. This includes office visit notes, lab work, EKG and Echo reports, and any other documentation from prior medical testing.

A variety of sources, including your primary care physician and specialty providers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record.

A patient's medical history is very important in helping providers treat your symptoms and/or illness properly. It is very important that you and your provider discuss all your medical history in order to ensure that your recorded medical history is 100% accurate.

When the patient has certain medical conditions or a significant past medical history, it is necessary for SAS to obtain medical records and clearance from your physicians before providing office-based anesthesia for elective dental procedures in the office setting.

I give my permission to allow Special Anesthesia Services to obtain my complete medical history from my primary care physician, any specialty doctors, and any other healthcare providers including the VA hospitals.

Date Completed _____

Signature of Person completing this form _____

Printed Name of Person completing this form _____

Relationship to the patient _____