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 appropriate measurement below

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 Pediatric Medical History

Date_____

Child's Full Name_____

DOB _____/_____/_____ Age_____

Gender: □ M □ F Height: _____ Weight: _____ □ kg □ lbs

Name/address/phone of primary physician _____

Date of last appt _____

Name/address/phone of medical specialists: _____

1) Is your child being treated by a physician at this time? Reason _____ □ Yes □ No
2) Has your child been ill in the past 6 weeks? Describe _____ □ Yes □ No
3) Is your child taking any medication (prescription/over-the-counter), vitamins, or dietary supplements □ Yes □ No
   List name, dose, frequency, and date started: _____
4) Has your child ever been hospitalized, had surgery or significant injury, or been treated in an ER?..... □ Yes □ No
   List date and describe: _____
5) Has your child, or family members, ever had a reaction to or problem with an anesthetic?..... □ Yes □ No
   Describe: _____
6) Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?..... □ Yes □ No
   List _____
7) Is your child allergic to latex or anything else, such as metals, acrylic, dyes, or foods?..... □ Yes □ No
   List _____
8) Is your child up to date on immunizations against childhood diseases? ..... □ Yes □ No

Please mark YES if your child has 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 your child.

9) Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions ... □ Yes □ No
10) Problems with physical growth or development ..... □ Yes □ No

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

13) Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease..... □ Yes □ No
14) Irregular heart beat or high blood pressure ..... □ Yes □ No

15) Asthma, reactive airway disease, wheezing, or breathing problems ..... □ Yes □ No
16) Cystic fibrosis ..... □ Yes □ No
17) Frequent colds or coughs, or pneumonia ..... □ Yes □ No
18) Frequent exposure to tobacco smoke ..... □ Yes □ No

19) Jaundice, hepatitis, or liver problems ..... □ Yes □ No
20) Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ..... □ Yes □ No
21) Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ..... □ Yes □ No
22) Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ..... □ Yes □ No

23) Bladder or kidney problems..... □ Yes □ No

Date Completed

Name/Signature of Person completing this form

Relationship to Patient

Printed Name of Person completing this form

24) Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ..... □ Yes □ No
25) Rash/hives, eczema, or skin problems ..... □ Yes □ No

26) Impaired vision, hearing, or speech ..... □ Yes □ No
27) Developmental disorders, learning problems/delays, or intellectual disability ..... □ Yes □ No
28) Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ..... □ Yes □ No
29) Autism/autism spectrum disorder ..... □ Yes □ No
30) Recurrent or frequent headaches/migraines, fainting, or dizziness ..... □ Yes □ No
31) Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous ..... □ Yes □ No

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

35) Diabetes, hyperglycemia, or hypoglycemia ..... □ Yes □ No
36) Precocious puberty or hormonal problems ..... □ Yes □ No
37) Thyroid or pituitary problems ..... □ Yes □ No

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

42) 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: _____

Is there any other significant medical history **pertaining to this child or their 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 – Pediatric

Your child will be receiving intravenous medications during his/her 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 child's safety that you strictly adhere to the following policies. Failure to do so will result in cancellation of surgery and can put the child 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/7 Up
    - Jell-O with NO fruit, vegetables or cream
    - Black coffee – no cream or sugar
3) Do NOT brush teeth, as child may swallow water and/or toothpaste, resulting in cancellation.
4) Do NOT send child to school or daycare. Children must be monitored by a parent or guardian at all times prior to appointment to verify adherence to above policies. Failure to do so will result in cancellation of appointment.
5) If your child has a prescription for breathing treatments, please bring his/her medication and nebulizer the day of the procedure.
6) Dress the child in comfortable clothing, preferably a shirt or blouse with short sleeves. Younger children will occasionally become relaxed enough to lose bladder control. **You may want to consider a diaper, pull up, or a change of clothing.**
7) Children require extra care during transportation home from their procedure. **It is highly recommended that two adults accompany the child so the driver does not have to attend to the child in transit.**
8) After your child's surgery, wait until the next day before allowing him/her to engage in any activity in which a decrease in alertness, judgement, or coordination could cause a problem.
9) After surgery, your child may take pain medication as directed by the surgeon.
10) Please bring appropriate guardianship paperwork, if necessary.

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

Patient	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