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

Adult 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
Husband		
Wife		
Partner/Significant Other		
Sibling		
Child		
Guardian		
Facility		
Case Manager/Worker		
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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Adult 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 the patient being treated by a physician at this time? □ Yes □ No

*Has the patient been ill in the last 6 weeks? □ Yes □ No

*Is the patient taking any medications? Please list name and dosage: □ Yes □ No

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

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

_____

*Has the patient 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 the patient currently has or has had in the past. Please describe all checked boxes in detail at the end of this form.

- □ Complications before or during birth, prematurity, or birth defects
- □ 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
- □ Shortness of breath/Chest Pain/Edema
- □ Coronary Artery Disease
- □ Cardiac Stents or Pacemaker/Defibrillator
- □ 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
- □ 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 or Placement of a Shunt
- □ Implanted Devices
- □ ADD/ADHD
- □ Behavioral, emotional, communication problems/treatment
- □ Abuse or Neglect
- □ Diabetes/Hyperglycemia/Hypoglycemia
- □ Precocious Puberty
- □ Hormonal Problems
- □ Thyroid/Pituitary Disorder
- □ Anemia
- □ Sickle Cell Disease or Trait
- □ Blood Disorder
- □ Hemophilia
- □ Easily Bruising
- □ Excessive Bleeding
- □ Blood Transfusions or blood products
- □ Cancer/Tumor/Malignancy
- □ Chemotherapy/Radiation
- □ Bone Marrow or Organ Transplant
- □ Scarlet Fever/Cytomegalovirus (CMV)
- □ Mononucleosis or Tuberculosis (TB)
- □ MRSA, STD, or HIV/AIDS

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

_____

_____

_____

_____

_____

Does the patient have uncontrolled Acid Reflux or Sleep Apnea? □ Yes □ No

Females age 18-55: Medications 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

Does the patient smoke, vape, or use any tobacco products? □ Yes □ No

How much per week? _____

Does the patient drink alcohol? □ Yes □ No

What type and how much per week? _____

Does the patient use recreational drugs? □ Yes □ No

What type and how much per week? _____

Is there any other significant medical history that was 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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SAS Patient Instruction Sheet

The patient 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 the patient's safety that you strictly adhere to the following policies. Failure to do so, will result in cancelled of the operative procedure and can put the patient 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 fruit, no vegetables, and no whipped cream
    c. Black coffee (No cream or sugar added)
3. Do NOT brush teeth on the morning of the appointment, you may swallow water or toothpaste and this will result in cancellation.
4. If the patient has an inhaler or nebulizer, please bring his/her medication on the day of the procedure
5. Dress in comfortable clothing, preferably a short sleeve shirt. Sedation can occasionally cause the patient to become relaxed enough to lose bladder control. **You may want to consider a depends or a change of clothes.**
6. Arrange for transportation form the dentist/surgeon's office to your home after the procedure.
7. After your surgery, wait until the next day before engaging in any activity which a decrease in alertness, judgement, or coordinator 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:

Signature of Person completing this form _____

Relationship to the patient _____

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SAS Deposit Form

Special Anesthesia Services requires a 25% non-refundable deposit from all patients. This is typically due 3 weeks in advance, however, many times a patient is not scheduled three weeks in advance. In that case, a deposit is due as soon as possible before the scheduled sedation appointment.

Deposits will be returned if the patient is not medically cleared for Office Based Anesthesia.

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**.

The standard fees for Office Based Anesthesia are based on an estimate of time. The estimate will come from your dentist and the fees for our services will be based off that estimate. If the procedure were to take longer than the estimate, the fees for the service will go up or if the procedure were to take less time, the fees for the services will be less. At the end of the sedation appointment, an accurate calculation of fees will be given and collected at the time of service. **All fees are due in full at the time of service.**

Time Estimate	Standard Fees	Deposit Amount		Time Estimate	Standard Fees	Deposit Amount
30 minutes	$483	$120		2 hours 30 minutes	$1035	$260
45 minutes	$552	$140		2 hours 45 minutes	$1104	$275
1 hour	$621	$155		3 hours	$1173	$295
1 hour 15 minutes	$690	$175		3 hours 15 minutes	$1242	$310
1 hour 30 minutes	$759	$190		3 hours 30 minutes	$1311	$3330
1 hour 45 minutes	$828	$210		3 hours 45 minutes	$1380	$345
2 hours	$897	$225		4 hours	$1449	$360

Please sign this form stating that you understand the deposit information above and that the deposit is non-refundable for the upcoming dental sedation appointment.

Date Completed _____

Signature of Person completing this form _____

Printed Name of Person completing this form_____

Relationship to the patient _____