# MOBILE ANESTHESIA FOR CHILDREN

Patient Name _____, _____ _____ Sex: M F
Last First MI

Date of Birth _____/_____/_____ Age _____ Height _____ Weight _____ Date of last medical exam _____

Name of Father/Guardian_____ Name of Mother/Guardian_____

Address _____, _____, _____ _____
Address City State Zip Code

Home Phone (_____) _____-_____ Cell Number (_____) _____-_____ Alt. Number (_____) _____-_____

Emergency Contacts
1._____ Ph (____) _____-_____ 2._____ Ph (____) _____-_____

Name of Physician/Clinic _____ Phone (_____) _____-_____

## MEDICAL HISTORY

**Previous General Anesthetic: □ Yes □ No Any Problems?**_____

List all medications child is taking (include vitamins, supplements, laxatives, and steroids, over the counter medications): Taken in the past 2 weeks_____

Does your child have any allergies? No □ Yes □ □ Drugs _____□ Other _____

| | | |
|---|---|---|
| 1. | Is your child in good health?_____ | Yes No |
| 2. | Has there been any change in your child's health in the past year? _____<br>If yes, what? _____ | Yes No |
| 3. | Is your child under the care of a physician?_____<br>If yes, for what? _____ | Yes No |
| 4. | Has your child ever had any serious illness, operation or been hospitalized in the past 5 years?_____<br>If yes, for what? _____ | Yes No |
| 5. | Is your child taking any medicine(s) including non-prescription medicine not listed above? _____ | Yes No |
| 6. | Does your child have, or had, any of the following diseases or problems? _____<br>Damaged or artificial heart valve(s), heart murmur, rheumatic heart disease. | Yes No |
| 7. | Does your child have, or had asthma, bronchitis, or respiratory problems, if so when_____<br>Were they hospitalized? If so when _____ | Yes No |

***I understand that withholding any information could seriously jeopardize the safety and health of the patient. Therefore, I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.***

If you are completing this form for another person, what is your name? _____

What is your relationship to the patient? _____

Signature of Parent/Guardian _____ Date _____

Reviewed by _____ Date _____

Revised 6/2010

# MOBILE ANESTHESIA FOR CHILDREN

## Informed Consent for Anesthesia

I, _____, hereby authorize and request duly licensed anesthesiologists and nurse
(self or legal guardian)
anesthetists associated with Mobile Anesthesia For Children to perform anesthesia on _____
( patient)
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.

The most frequent side effects of any IV anesthesia are drowsiness, nausea/vomiting, and phlebitis. Most patients remain drowsy or sleepy for the remainder of the day following their surgery. As a result, coordination and judgment will be impaired for as long as 24 hrs. It is recommended that children remain in the presence of a responsible adult during this period. Nausea and possible vomiting following anesthesia will occur in 10-15% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site which 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 rarely there are complications of anesthesia including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, pneumonia, stroke, brain damage, heart attack and death. I further understand and accept the risk that complications may require hospitalization. I have been made aware that the risks associated with local anesthesia, conscious sedation and general anesthesia vary. Of these three, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk. However, it must be noted that local anesthesia sometimes is not appropriate for every patient and every procedure.

Since medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of coordination, I have been advised of the necessity of direct parental supervision of my child for twenty-four hours or longer until fully recovered from the effects of the anesthetic, medications and drugs that have been given to my child.

I have been fully advised and completely understand the alternatives to sedation and general anesthesia. I accept the possible risks, side effects and dangers of anesthesia. I acknowledge the receipt of and understand both the pre-operative 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 child's anesthesia, and I am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure. The anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability from the anesthesia performed.

Signed _____ Relationship _____

Print Name _____ Date _____

Witness _____

Mobile Anesthesia for Children
9302 N. Colton Street, Suite #100
Spokane, WA 99218
509-863-9460

# MOBILE ANESTHESIA FOR CHILDREN

**Patient: _____, _____ __ Date of Birth ___/___/___**
Last First MI

## FINANCIAL AGREEMENT

Payment for anesthesia is due on the day of treatment. Method of payment must be confirmed prior to the appointment date. Please indicate your source below:

☐ Dental Insurance* ☐ Primary ☐ Secondary ☐ Cash ☐ Credit Card ☐ Medical Coupon
**for dental insurance, please fill out a INSURANCE INFORMATION FORM.*

**WE WILL FURNISH YOU WITH A RECEIPT SO YOU CAN BILL YOUR MEDICAL INSURANCE.**

**Signed: _____ Date: _____**
Parent or Legal Guardian

## CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, do hereby grant permission to: Mobile Anesthesia for Children and its providers, to release to my private insurance carrier, or the Department of Social and Health Services, any information contained in the medical record of the above named patient, what would be deemed necessary for payment of treatment provided.

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment records, referral and consultation recommendations and reports, and other related materials.

I also allow the taking of photographs to establish dental conditions or, with obscured identity, for educational purposes.

I hereby authorize payment of the insurance benefits to Mobile Anesthesia For Children.

I further release the attending doctor, his (her) associates and staff, from any and all liability arising from compliance with this request and disclosure of the requested information.

I have received a copy of the Notice of Privacy Practices.

**Signed: _____ Date: _____**
Parent or Legal Guardian

# Mobile Anesthesia for Children

Dr. Mark Bottorff
9302 N Colton Street, Suite #100
Spokane, WA 99218
(509)863-9460

## ANESTHESIA FEES

| | |
|---|---|
| Mask Down | $400.00 |
| 60 – 90 minutes | $800.00 |
| Each add'l 15 minutes | $100.00 |

- Length of case is determined from start of anesthesia until patient is dismissed from the office.
- Payment in full is required the day of surgery.
- Fees are based on cash or credit card. VISA and MASTERCARD are accepted.
- We accept CareCredit.

As a courtesy to you, the dental & medical insurance billing will be done for you by our office as long as the necessary **Insurance Information Form is completely filled out**, giving ALL information required. This form is included in the paper work packet for your convenience. Dr. Bottorff is not contracted with any insurance companies. It is your responsibility to check with your insurance company regarding the anesthesia benefits prior to surgery, as we do not do any pre-authorizations.

I fully understand the above and agree to pay in full on the day services are rendered.

Signed _____ Date _____

# INSURANCE INFORMATION FORM

**PATIENT'S NAME**_____, _____, ____**DOB**___/___/____
Last First MI

**PARENT/GUARDIAN NAME** _____

**HOME ADDRESS**_____

**CONTACT PHONE #**_____

## PRIMARY DENTAL INSURANCE

Subscriber_____, _____, ____ Relationship to Patient _____
Last First MI

Date of Birth ____/____/____ SSN_____-_____-_____ Subscriber ID# (if different than SSN)_____

Insurance Company_____ Phone (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Group #_____ Employer_____

## SECONDARY DENTAL INSURANCE

Subscriber_____, _____, ____ Relationship to Pt _____
Last First MI

Date of Birth ____/____/____ SSN_____-_____-_____ Subscriber ID# (if different than SSN)_____

Insurance Company_____ Phone (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Group #_____ Employer_____

## MEDICAL INSURANCE

Subscriber_____, _____, _____Relationship to Patient_____
Last First MI

Date of Birth____/____/____ SSN_____-_____-_____ Subscriber ID# (if different than SSN)_____

Insurance Company_____Phone#:(_____)_____

Address_____City_____State_____Zip_____

Group/Policy #_____ Employer_____

**IF THERE IS <u>ANY</u> MISSING INFORMATION ON THIS FORM, WE WILL NOT BE ABLE TO SUBMIT A CLAIM ON YOUR BEHALF TO THE INSURANCE COMPANY.**

**THANK YOU FOR YOUR COOPERATION!**