

COMPLETE AND SIGN THIS PAPERWORK ~ THEN **RETURN BY: FAX, EMAIL, OR MAIL.** If emailing – bring it up in PDF, click on “SIGN” (upper right), then click on “ADD TEXT”, complete the forms and email back (use the PDF email option - upper left [envelope]). Retain page 3 for your information (Instructions).

Patient _____ Birthdate _____ - _____ - _____

Person Responsible For Account:

Name _____ Social Security # _____ - _____ - _____

Street Address _____

City _____ State _____ Zip _____ Phone# _____

Birthdate _____ - _____ - _____ Employer _____ Buss Phone# _____

Relationship to Patient _____

In Case of Emergency; Closest Relative Not Living With You:

Name _____ Phone# _____

A \$100 nonrefundable deposit is **required to schedule** your anesthesia appointment. The deposit is applied to the anesthesia fee the day of service. The deposit can be paid with credit card over the phone.

THE REMAINING BALANCE IS DUE THE DAY OF SERVICE.

Payment can be made with cash, money order, or credit card. Credit cards accepted: Visa, Discover, MasterCard, and American Express.

NO CHECKS ACCEPTED!

We accept **Care Credit** with “No interest” payment plans - available upon approved credit. To apply go to care credit.com

Insurance Info: We will provide you with an insurance form the day of service. You will need to sign and date it, and submit it to your insurance company. Any reimbursement should go directly to you.

Your signature below indicates that you understand, agree with, and give permission to the above policies, and that you have answered all the information contained herein truthfully.

Signature _____ Date _____

patient/parent/spouse/guardian

Patient's name _____ Male ___ Female Weight _____ Ht _____

Answer each of the following questions (this information is confidential):

- ___YES ___ NO Are you under the care of a physician? If yes: _____
- ___YES ___ NO Currently taking any medications? If yes LIST: _____
- _____
- ___YES ___ NO Any drug allergies/sensitivities? If yes LIST: _____
- ___YES ___ NO Hospitalized in past 5 years? If yes LIST: _____
- ___YES ___ NO Have you ever had anesthesia for surgery? If yes LIST: _____
- _____

Put an "X" by any of the following which you have had in the past or have presently:

- | | | | | | |
|------------------|-----------|-------------|-----------------------|-----------------------|--------------------|
| Heart Problems | Stroke | Asthma | Diabetes Type I or II | Psychiatric Treatment | Excessive Bleeding |
| Kidney Disease | Anemia | AIDS | Emphysema | High Blood Pressure | Rheumatic Fever |
| Venereal Disease | Cancer | Ulcers | Hepatitis A B C ? | Drug Addiction | Heart Murmur |
| Liver Disease | Glaucoma | Smoker | Tuberculosis | Fainting or Dizziness | Epilepsy/Seizures |
| Thyroid Disease | Arthritis | Chest Pains | Phen-Fen Diet | Echocardiogram | HIV Positive |
| Fibromyalgia | Anxiety | Depression | Bipolar | ADD or ADHD | Autism |

- ___YES ___ NO Any mental or physical disabilities? If yes LIST: _____
- ___YES ___ NO Do you Snore? ___ YES ___NO Do you have Sleep Apnea ? ___YES ___NO Do you use a CPAP/BiPAP machine?
- ___YES ___ NO Do you wear contacts? If yes – Do you take naps or sleep with them in? ___YES ___ NO
- ___YES ___ NO Are you very anxious/nervous about dental treatment?
- WOMEN: Are you pregnant? ___ YES ___ NO Are you nursing? ___YES ___ NO

SIGNATURE _____ Date _____ SIGNATURE _____ Date _____
 patient/parent/spouse/guardian Dentist Anesthesiologist

Consent for Anesthesia

I hereby consent to, and request David A. Gutzman, DDS to perform the anesthesia technique explained to me, and any other procedure deemed necessary, or advisable relative to the planned anesthesia. It is the understanding of the undersigned that Dr Gutzman will have full charge of the administration, and maintenance of the anesthesia, and that this is an independent function from the surgery/dentistry. Anesthesia provided will either be intramuscular (IM) and/or intravenously (IV), orally (premedication) or local anesthesia, and by inhalation (nasally - Nitrous Oxide and Oxygen). Dr Gutzman practices dental anesthesiology with a Class IV anesthesia permit issued by the State of Utah. Monitoring during the anesthetic will include automatic blood pressure cuff, EKG (heart), pulse oximeter (blood oxygen levels), capnography (CO2 levels), temperature, precordial stethoscope, and observation.

I have been informed and understand that occasionally complications of the drugs and anesthesia occur, including, but not limited to: tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. Some of these complications may require hospitalization and may even result in death.
Severe complications are rare.

WOMEN: I understand that anesthetics, medications, and drugs may be harmful to the unborn child, and may cause birth defects or spontaneous abortion (miscarriage), and I accept full responsibility for informing the anesthesiologist of a suspected or confirmed pregnancy.

I have had an opportunity to ask questions relative to my specific treatment, and had them answered to my satisfaction. I understand for the safety and protection of the patient that no family or friends are allowed in the operatory during the surgery.

I understand that this is not a release of liability form, but a consent to receive anesthesia, understanding that there are risks involved. I acknowledge the receipt of and understand both the preoperative and postoperative anesthesia instructions.

SIGNATURE _____ Date _____ SIGNATURE _____ Date _____
 patient/parent/spouse/guardian Dentist Anesthesiologist

Instructions For patients Prior To Anesthesia

- Eating and Drinking: Morning Appointment – NO food after midnight, clear liquids are fine up to 2 hours before appointment time
- Afternoon Appointment – A **light** breakfast is fine - carbohydrates **only** (cereal, toast, oatmeal) - **no** protein (no eggs, bacon, meats), must be finished by 6 hours before appointment time.
Clear liquids are fine up to 2 hours before appointment time.
- Medications: Discuss with Dr Gutzman which of your normal medications to take the day of the appointment.
- Change of Health: A change in health can affect the anesthesia, **please call us as soon as possible** to evaluate.
- Clothing: Wear comfortable, loose fitting clothes. Short sleeves please.
- Arriving: A responsible adult must drive you to the appointment.

Instructions For Patients Following Anesthesia

- Returning Home: The patient must be accompanied by a responsible adult at the time of discharge. Postoperatively the patient cannot drive, take a bus, or a taxi to return home. Patient cannot drive for 24 hours.
- Pain Management: Sensitivity, tenderness, or pain in the mouth can be expected after the treatment. Your dentist will prescribe any needed pain meds. Tenderness or bruising at the IM/IV site is possible, and if uncomfortable can be treated with applying warm moist heat to the site, and taking Ibuprofen. Take pain meds with food in the stomach.
- Eating and Drinking: Eating and drinking may be attempted whenever the patient desires (asks for). Start out easy with small amounts of clear liquids, and then soft foods when ready. No alcohol for 24 hours after anesthesia.
- Nausea and Vomiting: Some nausea or vomiting can occur postoperatively. The most common cause is movement while the patient is still dizzy (like motion sickness). Try to limit the patient's movement until the dizziness is gone. Eating too much food, too soon, can upset the patients stomach also. Swallowing blood and pain pills on an empty stomach will cause nausea/vomiting.
- Activity: After returning home the patient should rest for the first day and be attended by someone responsible. Keep the patient's head propped up on a pillow, and remove any gauze packs upon returning home.

If you have any questions or concerns call Dr Gutzman (801) 571-5665