dentTIVA

4729 Razor Creek Way, Louisville, KY 40299 (855) 226-3831, Fax (855) 631-0417

Dear _____,

Thank you for trusting DentTIVA® to provide you the safest and most effective IV sedation available at your Dentist. We are the unparalleled leader in Dentistry IV deep sedation.

We look forward to helping every patient think very positive about seeing the dentist. Many patients clearly see us as the best, and most affordable option compared with surgery centers and hospitals.

To help make your visit to the dentist office the best experience possible, there are forms that we ask you to complete as soon as possible. These include the following:

1. Pre-Anesthesia Questionnaire
2. Informed Consent
3. HIPAA Authorization
4. Pre and Post Anesthesia Instructions

These forms are attached to this letter, or you can print them on line from a computer by going to www.denttiva.com and click on "Patient Forms" in the Navigation Bar near the top of the web page.

Please complete these forms to the best of your ability. An Anesthetist will call you prior to the day of your appointment. He or she will discuss your health history and answer any questions you may have about the information on the forms and your anesthesia. WE REQUIRE THAT THESE FORMS BE BROUGHT WITH YOU ON THE DAY OF YOUR APPOINTMENT. We reserve the right to cancel or postpone your appointment without refunding your deposit if you do not bring your completed forms.

PAYMENT FOR SERVICES:

Your dentist has contracted with DentTIVA® for providing IV anesthesia services.

You do not need to worry about paying a separate anesthesia fee. Our fee is included in the fee your dentist charges.

Insurance: Only in very rare instances will medical insurance pay for dental IV anesthesia no matter your level of anxiety.

If you want to submit your bill as a claim to your medical Insurance company we can provide you with the procedural codes. You will need to contact your Primary Care Physician or Specialist to obtain appropriate diagnosis codes that qualify for anesthesia reimbursement. We no longer submit claims to insurance companies.

We are glad you have decided to use DentTIVA® dental anesthetic services. We look forward to making your dental care possible as you "Sleep for your smile".

Sincerely,

C. Paul Bowen, CRNA, President

dentTIVA 4729 Razor Creek Way, Louisville, KY 40299 (855) 266-3831 Fax: (855) 631-0417

Anesthesia Patient Health Questionnaire (Pediatric) Initial Here_____

Child's Name _____ Weight _____ lb. Nickname _____

Your Name _____ Address_____

Your Relationship to Child _____ _____

Your Home Phone _____ _____

Pediatrician or Clinic _____

Work/Cell Phone _____ Pediatrician Phone _____

Child's Medical History

1. Medication or Food Allergies:

☐ None Known

☐ Yes If Yes, to what? _____

_____

2. Medications:_____

_____

_____

3. Previous Surgery or Anesthesia

☐ None

☐ Yes (If yes, please write them): _____

_____

_____

4. Previous Hospitalizations:

☐ None

☐ Yes (If yes, please write them below)

At what age?_____

What hospital?_____

Reason for Hospitalization:_____

Procedure(s):_____

_____

_____

5. Any problems with anesthesia in the past?

☐ None

☐ Yes If yes, what happened?_____

_____

_____

Continue on to next page until page 4

Anesthesia Patient Health Questionnaire (Pediatric) Initial Here_____

6. Is there a family history of anesthetic problems?

- ☐ None
- ☐ Yes If yes, what happened? _____

_____

7. Was your child premature?

- ☐ No
- ☐ Yes
  - If yes, how early?_____
  - What was the birth weight? _____
  - Birth place: _____
  - Was your child in a neonatal intensive care unit?
    - ☐ No
    - ☐ Yes If yes, how long? ___
    - Was your child on a ventilator
      - ☐ No
      - ☐ Yes If yes, how long?_____

8. Has your child been on an apnea monitor?

- ☐ No
- ☐ Yes If yes, is he/she on one now?
  - ☐ No If no, when was it discontinued? _____
  - ☐ Yes

9. Has your child ever had chicken pox?

- ☐ No
- ☐ Yes

Chicken pox vaccine?

- ☐ No
- ☐ Yes

Has your child been exposed to chicken pox in the past 3 weeks?

- ☐ No
- ☐ Yes

Continue on to next page until page 4

Anesthesia Patient Health Questionnaire (Pediatric)

Initial Here_____

10.

Medical Problems (check if yes and explain)

- ☐ Cough or runny nose in past month _____
- ☐ Fever in the past month _____
- ☐ Sore throat or hoarseness in past month _____
- ☐ Difficulty breathing _____
- ☐ Croup (barking cough) or stridor _____
- ☐ Asthma or wheezing _____
- ☐ Pneumonia _____
- ☐ Acid Reflux or Heartburn _____
- ☐ Aspiration or choking episodes _____
- ☐ Swallowing or Eating Problems _____
- ☐ Heart Murmurs or Irregular Heart Beat _____
- ☐ Other Heart Problems _____
- ☐ Nausea, vomiting or diarrhea in past month _____
- ☐ Recent weight loss _____
- ☐ Kidney Problems _____
- ☐ Liver Problems _____
- ☐ Hepatitis _____
- ☐ Previous Blood Transfusions; when was the last transfusion?_____
- ☐ Bleeding Problems _____
- ☐ Anemia or low blood count _____
- ☐ Sickle Cell Disease _____
- ☐ Seizures _____
- ☐ Thyroid Problems _____
- ☐ Muscle or Bone Problems _____
- ☐ Cerebral Palsy _____
- ☐ Developmental Delay _____
- ☐ Snoring or sleep apnea _____
- ☐ HIV / AIDS _____

Continue on to next page until page 4

Anesthesia Patient Health Questionnaire (Pediatric)

Initial Here_____

11. Is your child able to keep up playing with children of similar age?

- ☐ Yes
- ☐ No If no, please explain _____

12. Are there smokers in the house?

- ☐ No
- ☐ Yes

Is there anything else we should know about your child? _____

_____

_____

Signature of Parent / Guardian _____Date _____

END OF QUESTIONNAIRE

Continue on to next page until page 4

CONSENT FOR ANESTHESIA SERVICES

dentTIVA

I,_____ , acknowledge that my doctor has explained to me that I or my child will have an operation, diagnostic, or treatment procedure— medical or dental related. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ Deep IV Sedation and General Anesthesia (IV= Intravenous)	Expected Result	Total unconscious state, possible placement of a tube into the nose mouth and windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia

☐ Moderate/Conscious IV Sedation (IV= Intravenous)	Expected Result	Total or partial amnesia, reduced anxiety and pain, Intermittent periods of brief unconsciousness Able to follow commands
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	An unconscious state, depressed breathing, injury to blood vessels Partial or total memory of the procedure Advancement to General Anesthesia with associated risks.

☐ I understand that my anesthesia may be advanced to DEEP IV SEDATION and GENERAL ANESTHESIA if Moderate IV Sedation is not effective as determined by my doctor or anesthetist.

☐ I prefer that my anesthesia NOT BE advanced to Deep IV Sedation and General Anesthesia and stopping the procedure IF the procedure being performed safely permits me to be awakened.

Signature_____ Date_____

Guardian Signature_____

DentTIVA HIPAA AUTHORIZATION

I, _____, give permission to DentTIVA (TIVA OBO L.L.C.) to use my protected health information, and/or disclose the my protected health information to:

- Anesthesia Billing Company, Inc.
- List your insurance company or companies:
  _____
  _____
- Your Primary Care provider(s) and/or skilled Nursing Facility Providers.

Information to be disclosed:

- Medical Records
- Dental Records
- Treatment Records
- Diagnostic Records
- Other: (If applicable)_____

This protected health information is being used or disclosed for the following purposes:

- Provider fee reimbursement. (ie. Third party insurance billing)
- Medical or dental consultations related to your treatment and continuity of care.

This authorization expires after one year.

If any person or entity listed above receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to DentTIVA at 4729 Razor Creek Way, Louisville, Kentucky 40299. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of Participant or Personal Representative Date

_____

Printed Name of Participant or Personal Representative

_____

Description of Personal Representative's Authority

dentTIVA For Children

PRE-ANESTHESIA INSTRUCTIONS-- Before coming to the Dentist office:

1. As you become aware, notify your DentTIVA® anesthetist if your child has recently experienced any sudden changes to his or her health as soon as possible. This is especially true for even mild colds or flu-like symptoms.

2. Your child may take regular medications with sips of water as instructed by your Anesthetist.

3. Arrange for transportation with a second adult for your return home.

4. Nothing to eat or drink for at least 8 hours before your appointment, except for regular medications. Clear liquids may be consumed up to 2 hours before your appointment.

5. Wear loose fitting clothing.

POST ANESTHESIA INSTRUCTIONS-- Leaving after your sedation:

1. During your surgery, your child will be given an anesthetic to make him or her comfortable and free of pain. This will be administered either by a fully-trained Certified Registered Nurse Anesthetist (CRNA), dental anesthesiologist (DMD), or physician (M.D.) anesthesiologist.

2. You are required to have a responsible second adult to help transport your child from the doctor's office after surgery. You or another responsible adult must stay with your child for the next 24 hours.

3. You may be unaware of the effects of the anesthetic for 24 to 48 hours, even though you may think your child looks and feels fine.

4. During this time, your child should not engage in any activity that could be harmful to him or her such as sports or horseplay.

5. You should provide your child with assistance when engaging in activities such as walking, climbing stairs, or going to the bathroom.

6. Your child should eat only very light, easily digested foods and liquids for the next 24 hours.

My signature below indicates that I have fully read and understand these post anesthesia instruction and that my anesthesia provider has fully explained any questions that I have regarding my responsibilities related to receiving anesthesia.

CALL 911 OR YOUR LOCAL EMS IN CASE OF AN EMERGENCY

_____
Patient Name

_____ Date:_____ Time:_____
Parent or Guardian Signature