

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 <a href="https://www.denttiva.com">www.denttiva.com</a> 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.

<u>Insurance</u>: Only in <u>very rare instances</u> 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



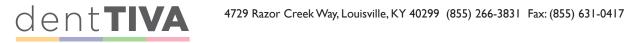
Anesthesia Patient Health Questionnaire (Po	ediatric)		Initial Here
Child's Name			
Your Relationship to Child		irėss	
Your Home Phone			
Your Home Phone			
Pediatrician or Clinic Work/Cell Phone		n Phono	
Work/Cell Frione	Fediatricia	an Fhone	-
Child's Medical History			
Medication or Food Allergies:			
☐None Known			
Yes If Yes, to what?			
2. Medications:			
3. Previous Surgery or Anesthesia			
☐ None ☐ Yes (If yes, please write them):			
Tes (ii yes, please write trieffi).			
4. Dravious Hespitalizations			 
<ol> <li>4. Previous Hospitalizations:</li> <li>■None</li> </ol>			
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?			

Initial Here

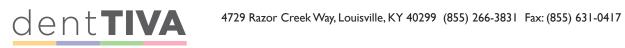


### Anesthesia Patient Health Questionnaire (Pediatric)

6. Is there a fa	amily history of anesthetic problems?
□None	
Yes	If yes, what happened?
7 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	hild nyamatı va O
-	hild premature?
□No	
Yes	and have and to 0
	es, how early?
	at was the birth weight?
	h place:
	s your child in a neonatal intensive care unit?
	]No
	Yes If yes, how long?
<u></u>	Was your child on a ventilator
	□No
	☐Yes If yes, how long?
8. Has your ch	nild 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 ch	nild ever had chicken pox?
□No	
Yes	
Chick	en pox vaccine?
C	]No
	]Yes
	our child been exposed to chicken pox in the past 3 weeks?
_	]No
	]Yes



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	
THIV / AIDS	



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** 

## CONSENT FOR ANESTHESIA SERVICES



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:
Very Drive en Core presidente and en elitted Numeire. Feeilite Dresidente
<ul> <li>Your Primary Care provider(s) and/or skilled Nursing Facility Providers.</li> </ul>
Information to be disclosed:
Medical Records
Dental Records  Transfer and Bassards
Treatment Records     Diagnostic Records
<ul><li>Diagnostic Records</li><li>Other: (If applicable)</li></ul>
This protected health information is being used or disclosed for the following purposes:
Provider fee reimbursement. ( ie. Third party insurance billing)
<ul> <li>Medical or dental consultations related to your treatment and continuity of care.</li> </ul>
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 <u>clinical trial</u> , your right to <u>access is suspended</u> 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



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

- 1. As you become aware, <u>notify your DentTIVA® anesthetist</u> 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 <u>second</u> adult for your return home.
- 4. Nothing to eat or drink for at least 8 hours before your appointment, except for regular medications. <u>Clear</u> 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. <u>You are required to have a responsible second adult to help transport your child from the doctor's office after surgery</u>. 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			
Parent or Guardian Signature	Date:	Time:	