

Patient Name: _____

DOB: _____

Date of Request: _____

Dear Doctor,

The above patient is scheduled for dental treatment in our office. Due to the patient's level of cooperation and treatment needs, it will be necessary to treat this patient under general anesthesia. The following dental treatment is anticipated:

Dental restorations of _____ teeth.

Dental extractions of _____ teeth.

Anticipated date of treatment: _____

In the patient's best interest, and as recommended in the sedation guidelines of the American Academy of Pediatric Dentistry, a health evaluation is to be performed within three weeks prior to treatment. I would like to request that you complete the attached physical examination form and offer any suggestions that you may have regarding the medical management of this patient. If possible, **please fax a copy of this form to our office at (206)323-9107 and provide the patient with the original form.** Thank you for your assistance. Please contact me if you have any questions.

Sincerely,

Stephen J. Stuehling, D.M.D.

FORMS: WE NEED ALL FORMS COMPLETED AND RETURNED 2 WEEKS PRIOR TO APPOINTMENT
OFFICE EMAIL: INFO@LAKEVIEWKIDSDENTISTRY.COM

Lakeview Kids' Dentistry



Stephen J. Stuehling, DMD, PLLC

703 34th Avenue • Seattle, WA 98122 • (206)251-7638 • www.lakeviewkidsdentistry.com



NEW PATIENT INFORMATION - to be completed by dental office staff

Patient Name: _____ M / F DOB: _____ Today's Date: _____

Home Phone Number: (____) _____ Language Spoken: _____

Any health concerns from your office's medical history form? YES or NO
If YES, explain: _____

List All Legal Guardians' Full Names (first & last) and indicated relationship:
Name: _____ Relationship: _____ Cell Phone: (____) _____
Name: _____ Relationship: _____ Cell Phone: (____) _____

CASE INFORMATION

Proposed Appointment Date: _____ Est. Length of Dental Treatment: _____
H & P scheduled for: _____

MEDICAL/DENTAL INSURANCE INFORMATION

Private Insurance: send copy of both sides of insurance card(s) and dentist treatment plan.
DSHS: provide ID # below (ending in -WA).

1. Medical or Dental (Please circle one)

Insurance Company: _____

Subscriber Name, DOB and ID#: _____

Insurance Group Number & Employer: _____

Subscriber Address: _____

2. Medical or Dental (Please circle one)

Insurance Company: _____

Policy Holder Name and SSN# / ID#: _____

Insurance Group Number & Employer: _____

Subscriber Address: _____

3. Medical or Dental (Please circle one)

Insurance Company: _____

Policy Holder Name and SSN# / ID#: _____

Insurance Group Number & Employer: _____

Subscriber Address: _____



ANESTHESIA

HISTORY AND PHYSICAL / PRE-ANESTHESIA EVALUATION

Fax directly back to 1 (206) 787-9002

Patient Name: _____ DOB: _____
is being evaluated for General Nasal Endotracheal Anesthesia during Elective Pediatric Dentistry in an outpatient dental office setting.

Pertinent Medical/Surgical History: _____

Pertinent Family History / History of Anesthesia Complications (including family hx of malignant hyperthermia):

Medications: _____ Food/Drug Allergies: _____

REVIEW OF SYSTEMS

Cardiovascular: _____ Pulmonary: _____

Hepatic/Renal: _____ Endocrine: _____

Hematologic: _____ Gastrointestinal: _____

Genitourinary: _____ Neurologic: _____

Musculoskeletal: _____

PHYSICAL EXAM

Ht: _____ in/cm Wt: _____ lbs/kg BP _____/_____ HR _____ RR _____

General Appearance: _____ Neck: _____

Heart: _____ Abdomen: _____

Lungs: _____ Extremities: _____

HEENT: _____ Nervous: _____

Impressions/Summary: Please include classification of (mild/moderate/severe) and, where appropriate, (uncontrolled, poorly controlled or well controlled) when describing existing conditions/diagnosis.

PREOPERATIVE PHYSICAL STATUS CLASSIFICATION - based on your knowledge of this patient's health status, would you consider this patient:

- _____ A normal, healthy patient (ASA 1)
_____ A patient with mild systemic disease and no functional limitations (ASA 2)
_____ A patient with moderate or severe systemic disease that results in some functional limitation (ASA 3)
_____ A patient with severe systemic disease that is a constant threat to life and functionally incapacitated (ASA 4)

DISPOSITION - based on patient's medical history and present health status:

- _____ This patient is currently fit for general anesthesia in an outpatient office setting
_____ This patient is fit for general anesthesia pending obtaining appropriate results for the following studies:

_____ I wish to further evaluate this patient prior to general anesthesia

Physician Signature: _____, M.D. / D.O. Phone: (_____) _____

Print Name: _____ Date: _____ Fax: (_____) _____



Frequently Asked Questions - General Anesthesia

What are the Risks of Anesthesia?

A common concern of any parent/ guardian whose child is having dental surgery is whether the anesthesia will cause any harm. Anesthesia today is much safer than it has ever been, however all anesthesia has an element of risk. Sometimes it is difficult to separate the risks of anesthesia from the risks of the dental procedure/surgery itself. Anesthesia serves to take away the pain and anxiety of surgery thereby making it easier for a procedure to be accomplished optimally and these benefits must be weighed against the risks of anesthesia itself.

Types of Risk

Anesthesia risk may be looked at in terms of side effects and adverse effects.

A side effect is a secondary or unwanted effect. Many side effects of anesthesia drugs can be anticipated, but may be unavoidable. Fortunately, most common side effects are not particularly dangerous. They will either wear off or can be treated easily. Examples of side effects are nausea, vomiting, drowsiness, dizziness, sore throat, shivering, aches and pains, and agitation upon awakening from anesthesia.

An adverse effect is a result that is neither intended nor expected. Adverse effects are very rare, but may occur. These may include dental trauma, croup (swelling of the windpipe), allergic reactions to drugs or latex products, wheezing, vocal cord spasm or injury, regurgitation of stomach contents with subsequent aspiration pneumonia, injury to arteries, veins or nerves, alterations in blood pressure, and/or irregular heart rhythms. Death and brain damage are the most feared of all anesthetic risks, but fortunately these complications are extremely rare. In the United States, the chance (risk) of a healthy child dying or sustaining a severe injury as a result of anesthesia is much less than the risk of traveling in a car.

Ways to Reduce Risk

- Sharing all information about your child's health (including all medications your child is taking, even those that can be obtained without a doctor's prescription) with the anesthesiologist prior to the procedure. This will allow the anesthesiologist to make a decision as to which type of anesthesia and drugs are safest for the patient
- Strictly following NPO, the guidelines you are given regarding eating and drinking before the operation
- Continuing usual medications unless the anesthesiologist or dentist recommends against it
- Ensuring that any other chronic illnesses are being optimally treated
- Having an anesthesiologist who is experienced in the care of children

Most children who undergo anesthesia will be quite comfortable and have no complications. They will be able to go home the same day as the procedure.

If you have any questions, please call Dr. Kim at (206) 605-5321



CHILD HEALTH HISTORY FORM

Name of Pediatric Dentist:

DR. _____

PATIENT INFORMATION: (CONFIDENTIAL) Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

RESPONSIBLE PARTY:

Name of Person Responsible: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Cell Phone/Pager: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY:

Has your child ever had or have any of the following medical problems? If YES, please explain.

- | | | | | | |
|----------------------------|----------------------------|--|----------------------------|----------------------------|---------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Allergies to any foods/drugs | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Hospital Stays/Admissions | <input type="checkbox"/> Y | <input type="checkbox"/> N | Seizures / Epilepsy |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Surgical Operations | <input type="checkbox"/> Y | <input type="checkbox"/> N | Handicaps / Disabilities |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart or Valve Defects | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cerebral Palsy |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma / Lung Conditions | <input type="checkbox"/> Y | <input type="checkbox"/> N | Developmentally Delayed |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Hepatitis / Liver Conditions | <input type="checkbox"/> Y | <input type="checkbox"/> N | Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Conditions | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Bleeding Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hearing Impairments |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Murmurs | <input type="checkbox"/> Y | <input type="checkbox"/> N | Tuberculosis |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Latex Allergy | <input type="checkbox"/> Y | <input type="checkbox"/> N | Autism / Down Syndrome |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Family history of problems with General Anesthesia | | | |

Please discuss any medical problems that the child has/had: _____

Child's Physician: _____ Phone Number: _____

Is the child currently under the care of a physician? Yes No Date of Last Visit: _____

Please describe the child's current physical health: Excellent____ Good____ Poor____

Please list all medications your child is taking: _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform Dr. Hanna Kim of any changes in the medical status of my child at the earliest possible time.

Signature of Parent or Legal Guardian _____ Date _____

Reviewed by: _____ Date: _____



FINANCIAL AGREEMENT FOR ANESTHESIA SERVICES

Patient Name: _____ Date: _____

Procedure: _____

Estimated anesthesia time & fee: _____

Anesthesia fees:

\$ 800 for the first hour

\$ 800 for each additional hour (billed in 15 minute increments after 1 hour)

Anticipated method of payment (circle one):

Cash Check or Visa/Mastercard (+ 3% fee)

The estimated anesthesia fee is based upon the dentist's estimate of treatment time and includes anesthesia preparatory time and the patient's response to the anesthetic used.

Payment for anesthesia services is due the day of treatment. In the event anesthesia time exceeds the estimate, the patient is responsible for the additional charges. However, if the anesthesia time is less than the estimate, the patient will receive a prorated refund.

Many insurance policies do not pay for anesthesia services for dentistry. Please check with your insurance company regarding your benefits. As a courtesy, our office will submit an anesthesia claim to your dental insurance after the day of surgery.

***** PLEASE SUBMIT PHOTOCOPY OF YOUR INSURANCE CARD*****

I understand that if I fail to pay the anesthesia fees, I will be charged an interest of 18% APR and will be liable for all the collection charges and or court fees.

I have read, understand and agree with the above **estimate** of fees.

Print Patient's Name: _____ Phone: _____

Print Parent/Guardian's Name: _____ Date: _____

Signature: _____



INSTRUCTIONS BEFORE ANESTHESIA

Eating or Drinking

FAILURE TO STRICTLY FOLLOW THESE INSTRUCTIONS COULD RESULT IN ASPIRATION AND MAY BE FATAL. For anesthesia it is extremely important that patients have an empty stomach, and the following instructions are to be followed.

*****No foods or liquids (includes water/candy/gum) after 10 PM the night before appointment*****

Clothing

Please wear a short sleeve loose shirt. Children should bring a light blanket. For children who do not wear a diaper or pull up, a change of clothes should be available. Do not wear makeup or nail polish. Contact lenses must be removed before anesthesia. Please do not bring anything valuable or wear any jewelry.

Change in Health and Medications

A change in health, especially the development of a cold or fever, is extremely important. Please notify Dr. Kim if there is any change in your health. Prescription medications should be taken as scheduled unless previously indicated by Dr. Kim and may be taken only with sips of water.

Designated Driver

A responsible adult must accompany any patient to the office and remain during the procedures. Do not plan on driving or making decisions for twenty-four (24) hours after the anesthesia. Arrange to have a responsible adult spend the rest of the day with your child. Children should be in a car seat.

Questions

Prior to your appointment, Dr. Kim will contact you to review preoperative instructions and to answer any questions. If you would like to discuss your anesthesia before this appointment, you may call Dr. Kim at (206) 605-5321.

Please note: parents/family members are not allowed in the dental operatory. This is for your child's safety so that each person taking care of your child can focus 100% of their attention to your child.

INSTRUCTIONS AFTER ANESTHESIA

Pain or Fever

Muscle aches and a sore throat may occur similar to the flu. This is very common after general anesthesia or sedation and will usually disappear within 24 to 36 hours. Drugs such as Tylenol and Advil are usually very effective and should be taken at the first sign of pain, if normally tolerated. For children, a fever of up to 101 degrees Fahrenheit may develop for the first 12 hours. Tylenol elixir every 3 to 4 hours with plenty of liquids will tend to alleviate this condition as well as treat any post-operative discomfort.

Diet

Limit oral intake to clear liquids for the first few hours. If teeth were extracted, do not drink through a straw. Initially, limit intake to clear liquids such as water, apple juice, or Gatorade. Once clear liquids are tolerated, slowly allow your child to try soft foods. Suggestions include applesauce, scrambled eggs, mashed potatoes, and soups. Avoid dairy products and citrus juices for the remainder of the day, as these may cause nausea and vomiting. If your child is not hungry, do not force him/her to eat but encourage him/her to drink liquids for the next twenty-four (24) hours.

Activity

Do not drive or engage in moderate to high physical activity for 24 hours or until the effects of the anesthetic have subsided completely. Judgment may be impaired during this time as well so do not allow your child to swim, bike ride, or play with other children. Place a blanket on the floor for the child to sleep on and observe him/her closely.

If you have any questions, please call Dr. Kim at (206) 605-5321



CONSENT FOR ANESTHESIA

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients more apprehensive but to enable them to be better informed concerning their treatment. There are basically four choices for anesthesia: Local anesthesia, conscious/deep sedation, general anesthesia, or no anesthesia. These can be administered, depending on each individual patient's medical status, in a hospital or in a private office. ()

The most frequent side effects of any intravenous infusion are drowsiness, nausea/vomiting, and phlebitis. Most patients remain drowsy/sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired. It is recommended that adults refrain from activities such as driving and children remain in the presence of a responsible adult. Nausea/vomiting following anesthesia will occur in 15-30% of patients. Phlebitis is a raised/tender/hardened/inflammatory response at the IV site. The inflammation 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 occasionally there are complications of the drugs and anesthesia including but not limited to: pain/hematoma/numbness/infection/swelling/bleeding/dyscoloration/nausea/vomiting/allergic reaction/stroke/brain damage/heart attack. I further understand and accept the risk that complications may require hospitalization and even may result in death. I have been made aware that the risks associated with local anesthesia, conscious/deep sedation, and general anesthesia will 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. Nerve damage from local anesthesia administration usually resolves, however, this may take over one year to heal. Nerve damage from local anesthesia administration may also be permanent. ()

I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother. ()

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination that can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least twenty-four hours, or until fully recovered from the effects of the anesthetic, medications, and drugs. I have been advised not to make any major decisions until after full recovery from anesthesia. Parents are advised of the necessity of direct parental supervision of their child for twenty-four hours following anesthesia. ()

I hereby authorize and request Hanna Kim DDS, to perform the anesthesia 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 that this is an independent function from the surgery/dentistry. ()

I have been advised of and completely understand the risks, benefits and alternatives of local anesthesia, sedation and general anesthesia. I accept the possible risks and dangers. I acknowledge the receipt of and understand both the preoperative and postoperative 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, or my child's, anticipated anesthesia and 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/dental treatment performed while under anesthesia and that the dentist assumes no liability from the anesthesia performed. ()

Print Patient's Name: _____ Date: _____

Legal Guardian (Print): _____ Legal Guardian (Signature): _____

Witness/Interpreter (Print): _____ Witness/Interpreter (Signature): _____

Outpatient Dental Surgery and Treatment Instructions and Information

Dear Parents,

In order to schedule your child for dental treatment under general anesthesia, please read the following information and the materials enclosed in the packet *carefully*. It has been determined, through mutual decision by you and Dr. Stuehling, that the appropriate treatment modality to safely and effectively complete your child's dental needs is to perform the necessary treatment under general anesthesia. If you have any questions about the enclosed information, please contact our office at (206)251-7638. The following information is based on the guidelines of the American Academy of Pediatric Dentistry, the anesthesiologist's surgery protocols, and our office. It is provided to help answer some of the most frequently asked questions and ensure that your child's treatment proceeds as safely and efficiently as possible.

Enclosed are informational handouts that discuss the day's procedure, how to prepare prior to the day of treatment, instructions for the day of treatment along with important numbers and steps required to schedule your child. Also enclosed is information regarding payment and billing information for both our office and the anesthesiologist. Please pay particular attention to the cancelation policy enclosed in the PAYMENT POLICY FOR OUTPATIENT DENTAL SURGERY.

Prior to Treatment

- Provide our office a copy of your Dental and Medical Insurance cards.
- If you have dental insurance, we will submit a pre-treatment estimate to you insurance company and accept assignment of benefits for treatment as a courtesy to you as our patient. It can take as long as thirty days for your company to process the pre-treatment estimate, longer if additional information is required. We will ask that you provided payment of the difference prior to treatment (See Payment Policy for Outpatient Dental Surgery). Please remember that this is a pre-treatment estimate and treatment may change, either more or less, once a thorough examination and x-rays are obtained while your child is comfortably sedated. We make every attempt to submit a complete treatment plan but this may be difficult if a thorough examination and x-rays were not possible in our office due to the extent of your child's anxiety.
- Set up a physical examination with your child's primary care physician or pediatrician. This physical must be completed no more than three (3) weeks prior to the surgery date. The physical examination is required by the Guidelines of the American Academy of Pediatric Dentistry and ensures that your child is healthy and that your pediatrician agrees with the treatment under anesthesia. A PHYSICAL

EVALUATION FORM is enclosed. After they have completed this form, **please instruct them to fax a copy to our office at (206)323-9107. Please bring the original form with you to the appointment.** A copy of this physical must be provided to our office at least seven (7) days before the scheduled surgery, unless prior arrangements have been made.

- Contact the office of the anesthesiologist who will be providing the anesthesia services. The medical and dental portions of the treatment will be billed separately. You will need to contact the anesthesiologist service to discuss their fees.

☒ Dr. < UbbU? ja (&S*) *S)!) ' &%.....]bZc4 ga]Y!Ubyh YgUWa

- All enclosed forms need to be signed and given to our office. This includes “Instructions to Parents...” and all appropriate consent for treatment forms.
- Payment in full for the dental services to be rendered is due the day of treatment. If you have dental insurance, we will accept the pre-treatment estimate that has been authorized by your dental insurance company along with your payment of the difference for the total dental services. Please see Payment Policy for Outpatient Dental Surgery.

We realize that this may seem like a lot to do, but is necessary to ensure that your child’s treatment proceeds safely and efficiently without delays. Please call our office if you have any questions regarding these instructions. (206)251-7638.

Post-Operative Instructions
For Patients Who have Received General Anesthesia for Treatment

It is important for your child's safety that you follow these instructions carefully. Failure to follow these instructions could result in unnecessary complications.

Activities DO NOT plan or permit activities for your child after treatment. Allow your child to rest. Closely supervise any activity for the remainder of the day. When sleeping, encourage your child to lie on his/her side.

Getting Home Two responsible adults must accompany your child. One adult should drive your child home and a second responsible adult must be available to take care of you child while driving home. Your child should be closely watched for signs of breathing difficulty and carefully secured in a car seat or seat belt during transportation.

Drinking or Eating after Treatment After treatment, the first drink should be plain water. Clear liquids can be given next (fruit juice, Gatorade, ginger ale, soup broth, tea, etc.). Small drinks taken repeatedly are preferable to taking large amounts. Soft, bland food, not too hot, may be taken when desired (scrambled eggs, mashed potatoes, apple sauce, Jell-O, ice cream, etc.).

Temperature Elevation Your child's temperature may be elevated to 101° (38°C) for the first 24 hours after treatment. Tylenol every 4-6 hours and fluids will help alleviate this condition. Temperature above 101°F (38°C) is cause to notify our office.

Extractions If your child has had teeth removed, a small amount of bleeding is normal. Do not let your child spit, as this will cause more bleeding. In order not to disturb the blood clot, DO NOT use a straw to drink for the first 24 hours. Minor bleeding is normal over the first couple of days following the extraction.

Brushing Since your child has had a cleaning and fluoride today, it is not necessary to resume brushing and flossing until tomorrow morning. However, it is very important for you to brush and floss your child's teeth beginning tomorrow morning, and on a daily basis thereafter, to prevent infection, and future dental problems.

Seek Advice

1. If vomiting persists beyond four (4) hours.
2. If the temperature remains elevated beyond 24 hours or goes above 101°F(38°C).
3. If there is any difficulty breathing or coloration of the skin is poor.
4. If any matter causes you concern.

If you have questions or concerns please contact our office at 206.251.7638. Dr. Stuehling can be reached at 206.898.5544 to address urgent health questions after regular business hours. Dr. ?|a can be fYUWYXat 206.*\$)'')' &%
Even though you child will have all dental treatment completed, it is important to maintain regular visits. Teeth with fillings can still get decay and/or lose the existing fillings if not careful.

Parent/Legal Guardian

Date

Reviewed by

Instructions to Parents of Pediatric Patients Who Are to Receive General Anesthesia for Dental Treatment.

General: It is important for your child's safety that you follow these instructions carefully. Failure to follow these instructions could result in serious complications or even death. If you are unsure of our recommendations, please contact our clinic.

General Anesthesia: This renders your child completely asleep. This would be the same as if your child was having their tonsils removed, or ear tubes placed. While the assumed risks are greater than that of other treatment modalities, if this is suggested for your child, the benefits of treatment this way have been deemed to outweigh the risks. Most pediatric medical literature places the risk of a serious reaction in the range of 1 in 25,000 to 1 in 200,000, far better than the assumed risk of even driving a car daily. The inherent risks, if this is not chosen are; multiple appointments, potential for physical restraint to complete treatment and possible emotional and/or physical injury to your child in order to complete their dental treatment. The risk of no treatment include: tooth pain, infection, swelling, the spread of new decay, damage to their developing adult teeth and possible life threatening hospitalization from a dental infection.

Change in Health: Please notify us of any change in your child's health.. Do not bring your child for treatment with a fever, ear infection, or a cold. **If your child becomes ill, please call our office immediately** and we will determine if we need to reschedule the appointment. A 24-hour notice will allow us to schedule another child needing treatment.

Eating and Drinking: To avoid complications and nausea, **DO NOT** allow your child to eat or drink prior to the surgery. The following dietary schedule **MUST** be followed:

- No milk, breast milk, or solid food after midnight prior to the scheduled procedure. This means **NO BREAKFAST**.
- Clear liquids **ONLY** (water, apple juice, Gatorade):
 - up to 4 hours prior to the procedure (children less than 3 years old)
 - up to 6 hours prior to the procedure (children 3-6 years old)
 - up to 8 hours prior to the procedure (children older than 6 years old)

Medications: Give your child only those medications that he/she takes routinely such as seizure medications, antibiotics, or other medications prescribed by your child's physician. **DO NOT** give any other medications before or after the treatment without checking with our office.

Arrival: Allow enough time to arrive at our office on time. Since we require you to be on time, we do our best to be on time as well. Unfortunately, the amount of treatment a patient needs can increase significantly after x-rays are obtained once the child is asleep. This can result in us running behind schedule. If there will be a significant change in your child's scheduled start time, we will make every attempt to notify you. A parent of legal guardian **MUST** accompany your child for all appointments. **DO NOT** bring any other children

with you to your child's appointment. He/she will require your full attention prior to and following the treatment. Please dress your child in loose fitting clothing. A monitor may be placed on your child's finger or toe, please remove any toe/fingernail polish prior to the appointment. Parents will not be allowed in the treatment room during the procedure. You will, however, be required to remain in the waiting room during treatment.

During Treatment: The anesthesiologist will place a special breathing tube, IV and monitors to maintain the anesthetic. This will be done once your child is safely asleep. This allows the anesthesiologist to carefully monitor your child while Dr. Stuehling performs the dental treatment.

The information contained in "The Instructions to Parents of Pediatric Patients Who are to Receive General Anesthesia for Dental Treatment" has been explained to me including the "Cancellation Policy". I have been given a copy of these instructions to read before beginning the procedure. All my questions have been answered to my satisfaction regarding these instructions. I will follow these instructions and understand that failure to do so may be life threatening to my child. I understand the risks of general anesthesia to my child. The proposed treatment and alternative treatment, including **no treatment**, have also been explained to me including the option to seek a professional second opinion.

Signature: _____ Relation to Patient: _____

Witness: _____ Date: _____

I certify that I explained the above procedures to the parent(s) or legal guardian before requesting their signature.

Doctor: _____ Date: _____

PAYMENT POLICY FOR OUTPATIENT DENTAL SURGERY

Please familiarize yourself with the following information regarding payment for you child's dental treatment. If you have any questions, please ask the Lakeview Kids' Dentistry office staff.

- Payment in full for the dental services to be rendered is required the day of treatment. If you have dental insurance, we will accept the pre-treatment estimate that has been authorized by your dental insurance company along with your payment for the difference of the total dental services. You are responsible for the difference and this payment is due to our office at the time of treatment.
- If you have dental insurance and wish to expedite the treatment for your child, you may choose NOT to wait for the pre-treatment estimate from your dental insurance company. If you choose this route, payment in full is due at the time of treatment and your company will reimburse you directly according to your policy.
- Due to the significant time and effort that is required to schedule and prepare for your child's treatment, a \$200 deposit may be required before a treatment time is reserved for your child. This deposit will be applied to any remaining balance after insurance has paid. If there is no remaining balance, the deposit will be refunded to you.

CANCELTION POLICY: If the anesthesiologist cancels the appointment because the patient has eaten/drank **against instructions**, you have failed to follow the directions outlined in "Instructions to Parents...", or if you **fail to show** for the appointment, the appointment will be rescheduled. If this occurs, the deposit will be forfeited. Also, if you cancel **without 48-hour notice**, the deposit will be forfeited. An additional \$200 deposit will be required to re-schedule. Significant preparation and time is required to treat your child under general anesthesia. **Please address all financial questions prior to the morning of treatment.** This allows the appointment to run smoothly and on time.

- Please understand that financial arrangements are made directly with you. You are responsible for the payment of your account. In addition, the parent or legal guardian who brings the child to our office is responsible for payment of all charges. We cannot send statements to other persons.
- **A Note About Dental Insurance:** We realize that your child's dental treatment under general anesthesia can entail a significant expense. As a courtesy to our patients, we have agreed to accept assignment of insurance benefits from your insurance carrier. As stated above, you are still responsible for you portion of the payment. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type of plan chosen by you and/or your employer. As such, we have no say in: the type of policy, we have no control over the terms of your contract, the method of reimbursement or the determination of your benefits. **Therefore, you are responsible for all payments if your insurance company has not forwarded payment to our office by thirty (30) working days after your child's treatment.**
- For the convenience of all our patients, we accept cash, personal checks, MasterCard or Visa.

Thank you for your understanding of our policies and trusting u sin the dental care of your child. Your cooperation is greatly appreciated. If you have any questions regarding this information, please call our office at (206) 251-7638.