sleep for dentistry
sedation and family dentistry

	Patient Name:
	Parent/ Guardian Name:
	Patient's Date of Birth: *(Day/Month/Year)*
Home Phone: Business: Cell:	Street Address: City: Postal Code:
Email Address: Consent for communication purposes: ❍ YES ❍ NO	
Spouse/Next of Kin: Spouse's Employer: Spouse's Contact Number:	Employer: Occupation:
OHIP #:	Anaesthesia/Sedation For Treatment ❍ YES ❍ NO
Referred by: ❍ Dentist ❍ Friend/Relative ❍ Website ❍ Other :	

Patient's Insurance Information

Primary Insurance Company:	Secondary Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Date of Birth: *(dd/mm/yy)*	Policy Holder's Date of Birth: *(dd/mm/yy)*
Group Policy#:	Group Policy#:
ID # or Cert #:	ID # or Cert #:

ANAESTHESIA: PATIENT WELFARE IS OUR FIRST CONCERN, therefore please note the following: Sedation patients must not have anything to eat for eight (8) hours, they may drink clear fluids only up to two (2) hours before an anaesthetic appointment. Patients must be accompanied home and supervised afterwards by a responsible adult for several hours. For all appointments, your ride must check-in at the office with you and remain in the office during your appointment. Patients must wear comfortable, non-restrictive clothing with short sleeves. Please wear flat shoes (no heels).

PAYMENT OPTIONS: As many of our patients have dental insurance, we will be pleased to provide you with an insurance form and/or estimate for planned treatment. **However, we cannot accept assignment of benefits. This means that your insurance cheque will be sent to you, not to our office. You are therefore responsible for full payment of your account following each appointment.** Please indicate which method of payment is preferred.
Please note: There will be a 10% service charge added to any accounts over 45 days.

☐ Visa/Mastercard Acct. # _____ Exp. Date: _____ ☐ Interac/Cash

Rescheduling or canceling an appointment requires 2 business days notice or you may be charged. This is to certify that I agree to the above policies and authorize payments, if required, towards the balance of my account. Furthermore, I consent to performing the dental procedures discussed and deemed to be necessary.

Patient Signature(or Parent/Guardian if patient is under 18 years old) :_____ Date:_____

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

Name: _____ Date of Birth:_____Ht:_____Wt:_____

Medical Doctor's Name, Address & Telephone
i._____ii._____

1. Have you been hospitalized or had any operations? (Please list & date)

   _____

   _____

2. Have you or your relatives had problems with sedation or anaesthesia, including malignant hyperthermia?

   _____

3. List pills, medications, or non -prescription drugs/supplements (with dosage):

   _____

   _____

   _____

4. Drug allergies or bad reactions (please list)

   _____

   _____

5. Any other allergies (e.g. latex, eggs, metal, hayfever)

   _____

6. Please checkmark, date and give details if you have/have had a history of the following:

○ Heart problems/Angina/Irregular heartbeat	○ Stroke
○ High/Low blood pressure	○ Bleeding disorder or anemia
○ Diabetes/Hypoglycemia	○ Dizziness, nervous disorders
○ Asthma, Persistent cough, Tuberculosis	○ Epilepsy, seizures or convulsions
○ Joint replacement	○ Mental health
○ Temporomandibular joint problems	○ Bruise easily
○ Hepatitis, Jaundice, Liver disease	○ Wear contact lenses
○ Kidney disorders	○ Recreational drugs
○ Thyroid disorders	○ Smoker? Yes / No ; How many per day?____
○ Gastric issues/Stomach bleeding/Ulcers	○ Alcohol consumption
○ Sleep Apnea/CPAP	○ Cancer/Oncologist info.

7. Do you have any condition that could affect your immune system? (e.g. AIDS, HIV, leukemia)

   _____

8. Are you pregnant? Yes / No Are you nursing: Yes / No

9. May we discuss your medical/dental treatment with your spouse, physician, parents, etc., if necessary? Yes / No

PATIENT/GUARDIAN SIGNATURE:_____**DATE**:_____

REVIEWED BY _____ BP_____ HR_____ SaO_2_____% Resp. rate_____ ASA_____
OTHER FINDINGS _____ UPDATES_____ BMI _____

sleep for dentistry
sedation and family dentistry

PATIENT INFORMATION/CONSENT FORM

Information is an important aspect of our patient's welfare, mainly because it brings to light some of the side effects, which may occur with anaesthesia. Once you, our patient, realize these possible occurrences, you can take steps to minimize them, just as we do.

One possible tissue response is called phlebitis. This does not occur very often, but if it does, may manifest as itching or burning in the arm, at the intravenous site. Very rarely, this may continue for a few days and some temporary numbness may be involved. If this occurs, we will instruct you on how to minimize the discomfort. This is not an allergy.

Nausea is another reaction that may be experienced occasionally. The best way to minimize this is to have nothing to eat eight (8) hours prior to an anaesthetic appointment. Clear liquids are permitted two (2) hours prior to an anaesthetic appointment. Examples of clear liquids are: clear fruit juices (pulp free), black coffee or tea (sugar is allowed but no milk, cream or whitener can be used), pop (regular or diet), Jell-O, popsicles, and water. However, if you are diabetic or take any medications at all, ask us about special rules with respect to food or fluids before your appointment. After a sedation appointment, eating light but nutritious foods is recommended. Gum chewing is not permitted prior to an anaesthetic appointment.

Finally, almost everyone will experience drowsiness to a different degree after a sedation appointment. For this reason, we ask our patients not to drive or work with machinery or sharp objects for 18 hours after a sedation. The best thing to do is to have a responsible person take you home (cannot be a taxi) and stay with you. Once you get home, rest as much as possible, drink a lot of fluids (non-alcoholic), and eat light, nutritious foods (e.g. bread with jam, soup or pasta). These measures will minimize the effects of feeling drowsy.

If you have any questions about any aspect of your treatment, please do not hesitate to ask us.

DATE: _____SIGNATURE: _____