sleep for dentistry
sedation and family dentistry

Patient Name:		Parent's Name (if patient is a child):	
Address:		City:	Postal Code:
Home Telephone:		Cell Telephone:	
Business Telephone:		Email Address: Consent for communication purposes ○ Yes ○ No	
Patient's Date of Birth: *(Day/Month/Year)*		Spouse/Next of Kin:	
Occupation:		Spouse's Employer:	
Employer:		Spouse's Business Telephone:	
OHIP #:		Referred by: ✓	
Anaesthesia/Sedation ( ) Yes For Treatment ( ) No		Friends Name	
		Dentist Name	
		Website/Internet	
		Other	

Patient's Insurance Information

Dental Insurance	( )Yes ( ) No	Insurance Company:	
Policy Holder's Name:		Policy Holder's Date of Birth: *(dd/mm/yy)*	
Group Policy#:		Policy Holder's ID # or Cert#:	
Policy Holder's Employer:		Do you have secondary insurance? ( )Yes ( ) No	

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 all afternoon 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

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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.

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

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

NAME:_____ DATE OF BIRTH:_____ Ht:____Wt:_____

Medical Doctor's Name, Address & Telephone
1)_____

2)_____

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** (eg . latex, eggs, metal, hayfever) _____
_____

6. **Please give details if you have a history of the following:**

- **Heart problems** (e.g. heart murmur, mitral valve prolapse , rheumatic fever, angina, irregular heart beat)_____
_____
- **High/low blood pressure, stroke**_____
- **Diabetes or Hypoglycemia**_____
- **Asthma, Persistant cough, Tuberculosis**_____
- **Joint Replacement Surgery**_____
- **Hepatitis, jaundice or liver problems**_____
- **Kidney or thyroid disorders**_____
- **Bleeding disorder or anemia**_____
- **Fainting, dizziness,nervous disorders**_____
- **Epilepsy, seizures or convulsions**_____
- **Sleep Apnea**_____
- **Smoker? Yes_____ or No_____ How many per day?**_____

7. **Do you have any condition that could affect your immune system** (e.g. AIDS, HIV, leukemia)**?**_____
8. **Women: Are you pregnant or nursing?**_____
9. **May we discuss your medical/dental treatment with your spouse, physician, parents, etc., if necessary?** Yes_____ No_____
10. **Is there any other information which may help us make your treatment more comfortable?**_____

PATIENTS SIGNATURE:_____DATE:_____
REVIEWED BY_____ BP_____ PULSE_____ASA_____
OTHER FINDINGS_____UPDATES_____

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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: _____