**Dr. Jay Patel**
**30 Knightsbridge Rd. Suite 525**
**Piscataway, NJ 08854**
**Tel. 732-986-3690 | Fax 732-601-4865**
**Email: info@dentsed.com**

DENTAL SEDATION SERVICES

# Patient Registration Form

| | |
|---|---|
| Patient Name: | |
| DOB: | |
| Sex: | |
| Marital Status: | |
| Street Address:<br>City, State, Zip: | |
| Telephone: | |
| Email: | |
| Employed: | Full-time ____ Part-time ____ |
| Unemployed: | Student/Part-time ____ Student/Full-time ____ Retired ____ |

## Emergency Contact Information

| | |
|---|---|
| Name/Relationship: | |
| Phone Number: | |

## Medical Insurance Information

| | |
|---|---|
| Medical Carrier: | |
| ID#: | |
| Group #: | |
| Claims Address: | |

## Secondary Insurance Information (if applicable)

| | |
|---|---|
| Carrier: | |
| ID#: | |
| Group #: | |
| Claims Address: | |

## Subscriber Information

| | |
|---|---|
| Name: | |
| Date of Birth: | |
| Relation to Patient: | |
| Employer: | |
| Street Address:<br>City, State, Zip: | |

Height: _____ Weight: _____

**Do you have any allergies?** ☐Y ☐N
Please list what you are allergic to and what your reaction is.

**Are you allergic specifically to EGG/SOY products?** ☐Y ☐N

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**Please list all medications** (List medication name, dosage, and when it is taken).

**Please list your physician(s), contact information, and date of last visit.**

| Physician Name | Phone Number | Date of Last Visit |
|---|---|---|
| | | |
| | | |
| | | |

**Have you had anesthesia for any other surgeries/procedures?** ☐Y ☐N
Please list surgery and month/year it was performed.

**Has anyone in your family had complications from anesthesia?** ☐Y ☐N
(If yes, please explain. Ex: Malignant hyperthermia, reaction to anesthesia)

**FOR WOMEN ONLY:**
**Are you currently, planning on, potentially pregnant OR nursing?** ☐Y ☐N

Date of last menstrual cycle: _____

**PLEASE CHECK ALL THAT APPLY**

| **CARDIOVASCULAR (HEART)** | **☐ALL NORMAL** |
|---|---|
| History of Chest Pain/Shortness of Breath | ☐ |
| Have you been rushed to an ER or Hospital, If yes, when? _____ | ☐ |
| Hypertension/High Blood Pressure | ☐ |
| High Cholesterol | ☐ |
| Heart Murmur | ☐ |
| Heart Defect | ☐ |
| Heart Arrhythmia/Atrial Fibrillation | ☐ |
| Heart valve disease/ valve replacement | ☐ |
| PCI/Angioplasty/CABG/Cardiac Stent(s), If yes, when? _____ | ☐ |
| History of Heart Attack, If yes, when? _____ | ☐ |
| AICD/Pacemaker | ☐ |

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**PULMONARY (LUNGS)** ☐ **ALL NORMAL**

- Asthma, If yes, last attack: _____ ☐
- COPD ☐
- Bronchitis/Pneumonia ☐
- History of Croup, If yes, when? _____ ☐
- Chronic sinus problems ☐
- History of nosebleeds ☐
- History of snoring ☐
- Obstructive Sleep Apnea, If yes, CPAP/BiPAP use? Yes_____ No_____ ☐
- Recent cold/flu symptoms ☐

**NEUROLOGICAL** ☐ **ALL NORMAL**

- Seizures, If yes, when? _____ ☐
- Epilepsy ☐
- History of fainting/losing consciousness ☐
- History of migraines ☐
- History of Transient Ischemic Attacks (TIA), If yes, when? _____ ☐
- History of CVA/Stroke, If yes, when? _____ ☐
- Fibromyalgia ☐
- Parkinson's disease ☐
- Dementia ☐

**GASTROINTESTINAL (STOMACH/INTESTINES)** ☐ **ALL NORMAL**

- Acid Reflux/GERD/Heart burn ☐
- History of nausea/vomiting ☐
- History of constipation ☐
- IBS/Crohn's disease ☐
- History of stomach ulcers ☐

**LIVER/KIDNEY** ☐ **ALL NORMAL**

- Hepatitis ☐
- Cirrhosis ☐
- Kidney insufficiency ☐
- Acute/chronic kidney failure ☐
- Hemodialysis treatment ☐
- Kidney stones ☐

**BEHAVIORAL/DEVELOPMENTAL** ☐ **ALL NORMAL**

- Anxiety ☐
- ADHD ☐
- Autism ☐
- Bipolar/Schizophrenia ☐
- Cerebral Palsy ☐
- Depression ☐
- Developmental Delay ☐
- Down syndrome ☐
- Mental retardation ☐
- Sensory disorder ☐
- Special needs ☐

**ONCOLOGY (CANCER)** ☐ **ALL NORMAL**

- History of Cancer ☐

Type: _____
Last Chemo Tx: _____, Last Radiation Tx: _____

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| | |
|---|---|
| **MUSCULOSKELETAL** | ☐ **ALL NORMAL** |
| Arthritis | ☐ |
| Degenerative joint disease/Osteoporosis | ☐ |
| Joint replacement in last 5 years | ☐ |
| Fibromyalgia | ☐ |
| Limited range of motion neck/back/arms | ☐ |
| Herniated/bulging disc | ☐ |
| **ENDOCRINE (HORMONES)** | ☐ **ALL NORMAL** |
| Diabetes Type I | ☐ |
| Diabetes Type II | ☐ |
| Hypothyroid | ☐ |
| Hyperthyroid | ☐ |
| Parathyroid disease | ☐ |
| Routine steroid use | ☐ |
| **HEMATOLOGY (BLOOD/BLEEDING)** | ☐ **ALL NORMAL** |
| Any type of anemia(s) | ☐ |
| Rheumatoid arthritis | ☐ |
| Enzyme deficiency/disorder | ☐ |
| Bleeding/clotting disorder | ☐ |
| History of DVT's / Pulmonary Embolisms | ☐ |
| Bleeding/bruising easily | ☐ |
| **SOCIAL HISTORY** | |
| Current or previous tobacco use? If yes, packs/day? _____ How many years? _____ | ☐ |
| Alcohol use, If yes, how often? _____ | ☐ |
| Recreational Drug Use, If yes, please explain? _____ | ☐ |
| **FOR PEDIATRICS** | ☐ **ALL NORMAL** |
| Was your child born PREMATURE/PRETERM? | ☐ |
| Did your child stay in the NICU? | ☐ |
| Did your child require a breathing tube after birth? | ☐ |
| **INFECTIOUS DISEASES** | ☐ |
| (If yes, please explain below. Ex: HIV/AIDS, Tuberculosis, Herpes) | |

**OTHER:**

Please list any additional information you would like the anesthesiologist to be aware of.

I hereby certify that the information I have provided herein is true and accurate to the best of my knowledge. RELEASE OF INFORMATION: I hereby authorize Dental Sedation Services to release any or all information acquired in the course of my examination and/or treatment. I understand this may include the release of any medical or other information required in the processing of claims for payment.

Print Name: _____

Signature: _____ Date: _____

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## HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information**
(Required by the Health Insurance Portability and Accountability Act)

---

1) Authorization:
    a. I, _____, hereby authorize the release of my Protected Health Information (PHI) to DENTAL SEDATION SERVICES.
2) Extent of Authorization:
    a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
3) This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment or other purpose as I may direct.
4) This authorization shall be in force for 1 year from the date signed, at which point the authorization will expire.
5) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7) If the patient is a minor or unable to provide their own legal consent, I am a parent, legal guardian, or personal representative authorized to provide consent on the patient's behalf.

| | |
|---|---|
| **Signature:** | **Relationship to Patient:** |
| **Print Name:** | **Date:** |

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DENTAL SEDATION SERVICES

# PRE-ANESTHETIC/ POST-OP PREPARATORY GUIDELINES

**IV Sedation/Monitored Anesthesia Care/General Anesthesia**

The following information outlines STRICT guidelines that you must adhere to prior to receiving anesthesia. Failure to do so could result in CANCELLATION of your case or possible COMPLICATIONS if not revealed to the doctor.

## Day ***BEFORE*** Appointment Instructions:

- ☐ No food, water, or milk should be taken after MIDNIGHT the day before your procedure. A light meal for dinner is preferred.
- ☐ A responsible ADULT in charge of taking you home and receiving post-operative instructions must accompany you to your appointment. Please arrange for this prior to your arrival.
- ☐ Inform your doctor of ALL MEDICATIONS you are currently taking. Some medications may need to be discontinued while others should be continued the morning of with a small sip of water. Your anesthesiologist will instruct you on this.
- ☐ If you are developing a cold, fever, sore throat, flu-like symptoms, or any other acute illness, inform your doctor's office immediately.
- ☐ Pregnant women CANNOT receive elective IV sedation/general anesthesia. If you are possibly pregnant or actively TRYING to become pregnant, please inform your doctor.
- ☐ Do NOT use tobacco products, drink alcohol, or use recreational drugs prior to your appointment, as they will interact with our anesthetic medications.

## Day ***OF*** Appointment Instructions:

- ☐ Do NOT eat or drink ANYTHING prior to your appointment unless instructed otherwise. This includes but is not limited to: sucking candies, lollipops, mints, etc.
- ☐ The adult accompanying you should not be distracted or have any other arrangements that day, as they will be responsible for your safety as you recover from anesthesia. Please refrain from bringing young children, as your chaperone will need to give you their full attention. They will also be given post-op instructions.
- ☐ Wear comfortable, loose-fitting clothing (T-shirt and pants), so that sleeves may be rolled up for IV placement and monitors. Do not bring unnecessary jewelry, watches, hairpins, etc. Do not wear excessive makeup, lipstick, or nail polish. Leave valuables at home.
- ☐ Do NOT wear contact lenses to your appointment. Glasses are preferred. If you must wear contacts, then please bring a storage container to remove them prior to your anesthesia.

## ***AFTER*** Anesthesia Instructions

- ☐ It is common to feel groggy, tired, and/or disoriented following anesthesia. We recommend someone be with you for 6 HOURS following discharge from the doctor's office. Do NOT operate motor vehicles or heavy machinery or make any important decisions for 24 hours, as you will still be recovering from the after effects of anesthesia.
- ☐ Nausea/vomiting can be a side effect of anesthetic medications. Follow our diet instructions to avoid nausea. If you still have nausea after 6 hours, please call the doctor's office.
- ☐ Diet instructions: Please start with clear liquids (i.e. water, Gatorade, ginger ale, pulp-less juices, etc.) as soon as you can tolerate it after your procedure. If you do not experience an upset stomach, continue on to soft foods (i.e. mashed potatoes, bananas, smoothies, Jell-O) for the rest of the day. Avoid heavy meals, spicy food, seeds/nuts, etc. for 24 hours. If you are diabetic, continue your usual meal regiment and insulin schedule as instructed by your primary doctor.
- ☐ Pain/swelling may be associated with your post-op experience. Bruising near IV sites, sore throat, and jaw discomfort are common following certain cases. This usually will resolve in 24-48 hours. Please contact your doctor's office if you still feel pain for an extended period.