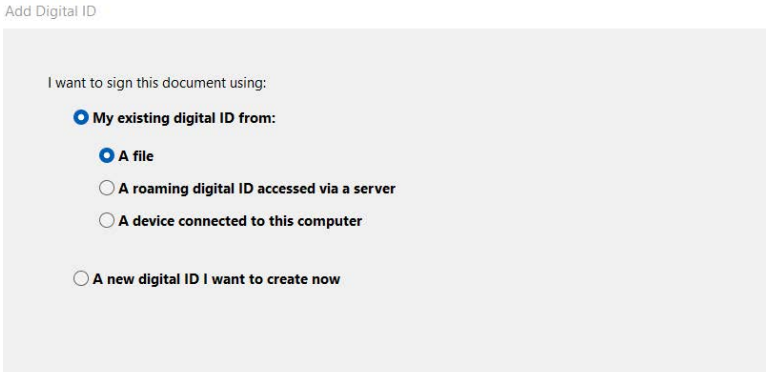
How to Sign this form

Please use Adobe Acrobat, Foxit, XODO, or any PDF viewer for desktop or mobile.

Desktop:

1. Click on the signature field
2. Fill out using your Digital ID. Follow the prompts.



- Note: If you don't have a Digital ID, please make one by following the prompts.

3. Proceed to submit this form. Read the last page to submit this form.

Phone:

1. Press on the signature field
2. You will be prompted to sign by drawing your signature on your device.
3. Proceed to submit this form. Read the last page to submit this form.

General Anesthesia Surgery

Please initial beside

_____ Nothing to eat or drink after midnight (this includes gum and lollipops)

_____ Wear a short sleeve shirt and bring a change of clothes (also a diaper or pull up if required)

_____ Medical and physical review form MUST be back in the office **no later than one week prior to surgery** or surgery can be cancelled

_____ If we cannot get a hold of you to confirm appointment the surgery can be cancelled

_____ If the child is under the age of 12, there must be 2 adults present to take the child home after surgery

_____ We strive to be on time and respect appointment times, however this is not always the case when it comes to general anesthesia and surgery

_____ Adults having surgery **MUST** have someone to drive them home and stay and monitor them for 24 hours

_____ Children must be supervised and monitored by an adult and not left alone for 24 hours

NORTHERN DENTAL CARE
Creating Beautiful Smiles

Consent for Pediatric/Adult Sedation and Dental Treatment

Patient's Full Name: _____ Date of Birth: _____

I hereby authorize Dr. Biasucci to perform the necessary dental treatment on me/my child under General Anesthesia.

I have been informed of the fees for the provision of sedation based on the type of sedation and duration of dental treatment per appointment, and that this fee may or may not be paid by any dental benefit plan.

I also understand that during the course of treatment, changes in the treatment plan may be necessary, and additional or alternate procedures may need to be performed. I give the dentist consent to make **any changes to the planned treatment deemed necessary by the dentist**, including additional fillings, removal of teeth, pulpotomy, or placement of stainless steel crowns. These circumstances often arise in the course of treatment of children, particularly where they were not cooperative in getting pre-treatment x-rays and much of the treatment plan is determined the day of anesthesia.

I acknowledge receiving a copy of the pre-operative and post-operative instructions which have been explained to me. After discharge, I will notify the above-named practitioner if experiences of acute pain, heavy bleeding from surgical sites, respiratory problems, or any other post-operative problems are encountered.

_____

Print Signature Date

_____

Witness Date

Informed Consent for Dental Treatment Under Sedation/General Anaesthesia

This Form Must Be Signed Before the Procedure

I understand that the following has been provided to me so that I may be informed of the choices and risks involved with having dental procedure performed under anesthesia. It is my understanding that this information has been presented to enable me to make well informed decisions concerning my treatment, **not to make me anxious**. My choices for anesthesia are local anesthesia alone, or in combination with conscious intravenous anesthesia, or deep sedation/general anesthesia.

I have been informed that aside from drowsiness, the most frequent side effects of any anesthetic occur in less than 15% of patients and include but are not limited to nausea, vomiting, sore throat, general muscle soreness and inflammation with tenderness and/or bruising around the intravenous site. Since anesthesia may cause drowsiness and incoordination that may be enhanced by use of alcohol or drugs, I have been advised to abstain from their use until completely recovered from the effects of anesthesia and prescription medicines. I understand that I should not operate any vehicle, any hazardous device/machine, or make any important decisions for at least 24 hours or until completely recovered from the effects of anesthesia. Parents are advised of the necessity for direct parental supervision of children for 24 hours following their anesthesia.

I understand that on rare occasions there are anesthesia related complications that include but are not limited to pain, hematoma, numbness, infection, swelling, bleeding, skin discoloration, allergic reaction, tooth damage, and fluctuations in heart rhythm and /or blood pressure. I further understand and accept the extremely remote possibility that complications may arise which may require hospitalization. I have been aware that local anesthesia carries with it the least amount of risk and deep sedation/general an a the most. However, local anesthesia alone is not appropriate for every patient or procedure.

I understand that an anesthetics and other medicines may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthetic. For similar reasons, I understand that I must inform the anesthesiologist if I am a nursing mother.

I hereby authorize and request the anesthesiologist or his staff to contact persons on my behalf and obtain any previous current medical records/information in order to properly assess my health status prior to anesthesia.

I hereby authorize and request the anesthesiologist to perform 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(s) by any route that is deemed suitable by the anesthesiologist. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia.

I have been fully advised and completely understand the alternatives to conscious sedation, deep sedation and general anesthesia, and accept all possible risks and consequences. I acknowledge receipt of and completely understand both preoperative and postoperative anesthesia instructions. It has been explained to me and I accept that there is no warranty or guarantees as to any result and/or cure. I have had the opportunity to ask questions about my anesthetic and am satisfied with the information provided to me.

Signed: _____ Date:_____

Print Name: _____

Witness: _____ Print Name _____

Patient Contact Information

PATIENT INFORMATION

Title: Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐

First Name: _____ Middle Name: _____

Last Name:_____ Age:_____ Date of Birth:____ /____ /____

Day Month Year

Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cellular Phone: ( ) _____

Email Address: _____

What is the best means to contact you by? _____ What days and times are best to contact you? Days_____Times_____

Dentist Name: _____ Phone:_____

CONTACT INFORMATION

Who is the best person to contact in case of an emergency?

Name: _____ Phone: _____ Relationship to you: _____

Who will be responsible for taking you home after anesthesia? **A taxi driver alone is not sufficient.**

Name: _____ Phone: _____ Relationship to you: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____ Certificate Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ____ / ____ / ____

Day Month Year

Name of employer insurance is through:_____

MEDICAL CARE INFORMATION

Family Physician: Dr._____ Phone:_____ Fax:

Address: _____

City: _____ Province: _____ Postal Code: _____

Pre-Anesthesia Questionnaire

Name: _____

		Yes	No	Not Sure
1.	Do you have any health problems or concerns presently?	☉	○	○
2.	Has there been ANY change in your general health in the past year? When did you last have a complete physical exam? (month)___ (year) ___ How often do you see your family doctor? Every_____	○	○	○
3.	Have you ever been in hospital for treatment? When, where and why? _____	○	○	○
4.	Have you ever had general anesthesia or surgery? Where, when and why? _____ Were there any problems with the anesthesia? _____	○	○	○
5.	Have you or any of your family relatives had problems with anesthesia? Please explain._____ Were any tests done? _____	○	○	○
6.	Do you have a drug allergy? What drug?_____ What year?_____ What happened?☐rash ☐breathing problems/wheezing ☐swelling	○	○	○
7.	Do you have any other allergies (e.g. latex)?	☉	○	○

8. Do you take ANY medications (including puffers and birth control pills)? ○ ◉ ○
   Please list or bring a list of all of your medications.
   Name: Dose:

9. Do you use or take ANY non-prescription remedies (including herbal)? ○ ○ ○
   Name:

10. Have you taken cortisone (steroid) type drug orally in the past year? ○ ○ ○
    When?_____How long were you taking it for?_____

11. Do you or any of your relatives have a bleeding problem? ◉ ○ ○

12. Do you have or have had any difficulty breathing through your nose? ◉ ○ ○

13. Do you have nose bleeds? If so, how many per week?_____ ○ ○ ○

14. Do you have or have had any difficulty breathing while sleeping? ○ ○ ○

15. Can you walk up 2 flights of stairs or 2 city blocks quickly without resting? ○ ○ ○

16. Please rate how anxious you are about dental exams and/or treatment (Please circle):

    Very relaxed ○1 ○2 ○3 ○4 ○5 Extremely Anxious

17. Do you have or have had any of the following?

	YES	NO	NOT SURE		YES	NO	NOT SURE
Heart Murmur	☐	☐	☐	Fainting spells, dizziness	☐	☐	☐
Heart attack	☐	☐	☐	Diabetes	☐	☐	☐
Chest pain or angina	☐	☐	☐	Thyroid problems	☐	☐	☐
Shortness of breath lying down	☐	☐	☐	Adrenal gland problems	☐	☐	☐
Swollen ankles	☐	☐	☐	Hepatitis	☐	☐	☐
Heart pacemaker/defibrillator	☐	☐	☐	Liver disease/jaundice	☐	☐	☐
Irregular heart beat/arrhythmia	☐	☐	☐	Anemia (including sickle cell)	☐	☐	☐
High blood pressure	☐	☐	☐	Blood disorders/transfusions	☐	☐	☐
Congenital Heart disease	☐	☐	☐	Bleeding (coagulation) disorders	☐	☐	☐
Damaged/abnormal heart valves	☐	☐	☐	Stomach ulcers/ acid reflux	☐	☐	☐
Rheumatic fever	☐	☐	☐	Bone, joint, or muscle problems	☐	☐	☐
Kidney disease	☐	☐	☐	Artificial joints (hips, knees)	☐	☐	☐
HIV, AIDS, or STD	☐	☐	☐	Arthritis	☐	☐	☐
Malignant hyperthermia	☐	☐	☐	Depression/anxiety	☐	☐	☐
Pseudocholinesterase deficiency	☐	☐	☐	Vision problems/Glaucoma	☐	☐	☐
Cancer/Chemotherapy	☐	☐	☐	Mentally disabled	☐	☐	☐
Sleep apnea	☐	☐	☐	Cerebral palsy	☐	☐	☐
Asthma	☐	☐	☐	Autism or Down's syndrome	☐	☐	☐
Emphysema/Bronchitis	☐	☐	☐	**WOMEN:**			
Cystic fibrosis/Tuberculosis	☐	☐	☐	Are you pregnant?	☐	☐	☐
Epilepsy	☐	☐	☐	Are you a nursing mother?	☐	☐	☐
Stroke	☐	☐	☐	Any problems with menstruation?	☐	☐	☐

	Yes	No	Not sure
18. Do you ever have episodes of blurred vision or black spots or experience weakness or paralysis on one side of your body, arms, legs or face?	☐	☐	☐
19. Do you have any problems opening your mouth wide or moving your neck fully?	☐	☐	☐
20. Have you ever had surgery, radiation or chemotherapy treatment for a tumor or cancer?	☐	☐	☐
21. Do you smoke? If so, how much? _____	☐	☐	☐
22. Do you drink more than 5 alcoholic beverages per week? Number per week ___	☐	☐	☐
23. Do you have a history of alcoholism or drug dependence?	☐	☐	☐
24. Have you taken "recreational drugs" in the past year such as marijuana, LSD, PCP, cocaine, crack, crystal meth, codeine, oxycodone or other drugs?	☐	☐	☐
25. Do you have ANY disease, condition or problem not listed above?	☐	☐	☐

26. **How much do you weigh? _____ Height: _____**

27. Additional comments: _____

Information provided by: _____ Relationship to patient: _____

Signature: _____ Date: _____

Nurse/Doctor Signature: _____ Date: _____

Please Keep This Form For Your Reference

The Week Before Your Appointment:

- **ARRANGE FOR SOMEONE TO HELP YOU GET HOME AFTER YOUR APPOINTMENT.** Public transit, motorcycles or walking are not acceptable modes of transportation. Adult patients are not permitted to drive and will require assistance from a responsible friend or relative. A taxi driver alone is NOT sufficient. Patients under 18 years old must be accompanied by a parent or guardian. Each patient under 18 must have **TWO** adults present for the ride home. **IF NO ARRANGEMENTS ARE MADE, YOUR APPOINTMENT WILL BE CANCELLED.**
- All patients should be accompanied by an adult that is capable for giving consent for treatment on their behalf.
- If you have a cold, flu, or persistent cough, fever, nausea, vomiting, diarrhea, or are still recovering from a recent illness, please contact our office at least 3 business days before your appointment.
- If you take any prescription or over the counter medications, consult the anesthesiologist about taking them.
- If you are a diabetic, please inform the anesthesiologist ahead of time.

The Day Before Your Appointment:

- **PLEASE CONFIRM THE PERSON WHO WILL BE TAKING YOU HOME AFTER YOUR APPOINTMENT. Each patient under 18 must have TWO adults present for the ride home after the appointment.**
- **DO NOT EAT OR DRINK ANYTHING FROM MIDNIGHT THE DAY OF YOUR APPOINTMENT**, this includes coffee, tea, juice, and milk, **EVEN WATER**. No chewing gum, or sucking on candies. **YOU MUST FAST 9 HOURS PRECEDING THE SEDATION/ANESTHETIC APPOINTMENT.**
- Food in the stomach may result in vomiting and subsequent pneumonia during anaesthesia. This is unsafe and can be FATAL. A light meal is strongly recommended for the evening before the anaesthetic appointment.
- Take your daily medications as usual with a sip of water unless otherwise directed by the anesthesiologist
- Please advise us of any recent changes in your health such as fever, vomiting, diarrhea, cold/flu prior to your appointment.

The Day of Your Appointment:

- If we have given you any medication to take before your anesthetic, please follow the directions carefully.
- Wear loose, comfortable clothing, **short sleeve top**, socks, (not tights or leotards) and flat shoes. Tie back any long hair.
- Do NOT wear contact lenses, as well as any make up or nail polish, hand/face cream/lotions.
- Do not smoke.
- Please bring a change of clothes for children or for appointments longer than 2-3 hours.
- Please arrive on time or a few minutes before your appointment.

During Your Appointment

- Monitoring devices will be used to track your vital signs throughout the entire appointment. These include a blood pressure cuff wrapped around your arm, a small sensor attached to your finger, and EKG leads placed on your chest.
- A small intravenous catheter will be placed in the back of your hand or within your inner elbow to deliver the IV sedation medication.
- It is normal to have bruising/marks from IV, monitors and tape.
- Most people wake up from the anesthesia with some degree of disorientation or confusion. For most, it takes about 10-15 minutes for the brain to fully “wake up”, even after they regain consciousness. The person who will take you home must wait until you’re alert enough to leave the office safely. The recovery time usually takes 20-60 minutes.

After Your Appointment

- **A RESPONSIBLE ADULT MUST ACCOMPANY YOU HOME IN A CAR OR TAXI AND STAY WITH YOU UNTIL THE NEXT DAY.** Rest for the remainder of the day. You are still under the influence of the anesthetic and your judgement might be impaired. Do not plan to make any important business or personal decisions, including the signing of legal documents.
- **DO NOT WORK OR DRIVE FOR 24 HOURS FOLLOWING ANAESTHESIA.**
- Drink plenty of fluids (water/juice) after anaesthesia but begin with frequent and small quantities. If you are not experiencing any nausea or vomiting, you may eat solid foods as tolerated. (Please begin with easily digested foods)
- **DO NOT CONSUME ALCOHOLIC BEVERAGES FOR 24 HOURS AFTER YOUR VISIT.**

Instructions for Patients Who Have Received a General Anaesthetic

The following information is intended for patients who have had dental treatment under general anaesthesia.

Additional post-operatory instructions will be provided to you if necessary.

- Have a responsible adult take you home in a car or taxi and stay with you until the next day. **Each patient under 18 must have TWO adults present for the ride home.**
- Rest for the remainder of the day.
- Drink plenty of fluids (water/juice) after the anesthetic but begin with frequent and small quantities. If you are not experiencing any nausea or vomiting, you may eat solid foods as tolerated (please begin with light, easily digestible foods).
- Do NOT work, drive a car, operate heavy machinery, or sign legal documents for at least 24 hours following the anaesthesia. You are still under the influence of the anesthetic and your judgement might be impaired.
- It usually takes several hours for general anesthetic to wear off. Every individual reacts differently and sometimes the same individual reacts differently to the same anesthetic at different times. As a result, you may not be fully recovered from the effects of the aesthetic for at least 24 hours after your visit.
- DO NOT CONSUME ALCOHOLIC BEVERAGES FOR 24 HOURS AFTER YOUR VISIT. Alcohol is not permissible and is not advisable if medications are being prescribed.
- Follow any post-operatory instructions provided to you by our office and by the anesthesiologist.
- Resume taking prescribed medications as directed, after your appointment.
- The area where the IV catheter was placed may be bruised for a few days after your visit.
- If local anesthetic ("freezing") was used, be careful not to bite your lips, cheek or tongue.
- A sore throat is common after anaesthetic.
- Taking antibiotics may cause a decrease in the effectiveness of the birth control pill. An additional type of birth control should be used when antibiotics are prescribed.
- The area where the IV catheter was placed may be bruised for a few days after your appointment. This is normal. If the site becomes sore and hard several days after your visit please contact your dentist immediately.
- There may be bruising or marks from monitors, blood pressure cuff and/or tape, especially if the patient has sensitive skin.
- The vein at the spot where the IV catheter was placed may become sore and hard several days after your visit. If this occurs, contact your dentist immediately.

Pre-Operative Anesthetic Questionnaire

Medication List

Please list all the medicines you are currently taking in the table below. Make sure you write down any:

- Prescription medications (such as antibiotics, blood pressure pills, pain killers and other pills, puffers, sprays, creams, patches, injections, or eyedrops)
- Non-prescription medications (such as Tylenol or Advil)
- Supplements (such as vitamins, minerals, or herbals)

Name of Medicine (Brand and Generic name, if available)	Strength	How do you take this medicine?			What do you take it for?
		How many each time?	How often?	When?	
Example: Atorvastatin (Lipitor)	*40mg*	*1 tablet*	*Once a day*	*In the evening*	*High Cholesterol*

If no medications please initial here: _____

Pharmacy: _____

Pharmacy Telephone Number: _____

Informed Consent for Oral Surgery

Patient Name: _____ Date: _____

Proposed Treatment:_____

This sheet serves as a quality control check list to ensure you understand the benefits, alternatives and risks. Your signature below indicates that we have discussed, and you understand the following:

- You decline being referred to an oral surgeon (a specialist in tooth removal)
- You have fully disclosed you medical history to us
- You are aware that significant post-op discomfort, swelling, bleeding, muscle soreness, jaw joint discomfort and bruising are expected outcomes of oral surgery.
- You are aware that there is a risk of nerve damage, particularly for lower tooth removal, which will result in numbness of the lip, chin, gums, tongue, teeth or cheek. This is usually of short duration but rarely may be permanent.
- You are aware that for the removal of upper teeth there is a risk of complications with the sinus, which may include a small opening to the sinus from the mouth, and may require you to see an oral surgeon at your own additional expense.
- You are aware of the risk of infection, as well as the risk of dry socket, which will result in pain and discomfort for which additional treatment will be required
- You are aware that there is a risk of damage to adjacent teeth, which will need treatment at an additional expense
- You are aware that during treatment the tooth may fracture and small root tips may be left behind or additional surgery may be needed to retrieve these fragments.
- Nausea, vomiting, delayed healing, allergic reaction and rarely fracture of the bone may occur.
- You are aware that long-term consequences of tooth removal may include shifting of teeth, bone loss where teeth were, collapse of your bite which can adversely affect your facial aesthetics and cause symptoms of TMD.
- You have been made aware of alternatives to this procedure including endodontic (root canal) therapy (if applicable) or replacement by means of dental implants (if applicable)
- You have no further questions about the proposed treatment, and your questions thus far have been answered to your satisfaction.
- The quoted fee may increase if the extractions are more difficult than anticipated.

I understand the above statements. All questions have been answered to my satisfaction. I give my informed consent to proceed with the proposed treatment.

Patient/Guardian Signature:

_____

NORTHERN DENTAL CARE
Creating Beautiful Smiles

Save this form, then click this button to email this form to us:

EMAIL NOW

If the button doesn't work for you:

1. **Save the changes to this form**
2. **Attach this form in an email to northerndentaldcm@altima.ca**