General Anesthesia Medical Information

Today's Date___/___/___

Preferred Location: Ladysmith/Chippewa Previous Dental Provider: _____

Patient_____ DOB_____ Age_____ Male ☐ Female ☐ Med HX Received ☐

Parent's Name_____

Phone Number_____ Additional Phone_____

Insurance Type_____ Other Health Insurance_____

Consult Type_____

Patient's Weight_____ Time Needed_____

OR Date_____☐ Urgent / Labs Needed / First Available / Interpreter needed / Coordinate with another surgery

Pediatrician or Family Physician_____

Clinic _____Phone_____

Health History

☐ Non-Contributory

Hospitalization History _____

Illness History _____☐ Cancer ☐ Heart Problems ☐ Lung Problems ☐ Kidney Problems ☐ Seizures

☐Heart Conditions Type_____

Specialist's Name_____

Comments_____

Antibiotic prophylaxis needed ☐ Yes☐ No

☐Hematology/Oncology Type and Treatment Received _____

Specialist's Name_____

Comments_____

Antibiotic prophylaxis needed ☐ Yes ☐ No Infusion needed

☐Yes ☐ No If so type of infusion_____

Overnight stay required ☐ Yes ☐No

☐Diabetes Type_____

Specialist's Name_____

Comments_____

Insulin dependent ☐ Yes ☐ No

Overnight stay needed ☐ Yes ☐ No

Type and considerations_____

☐ Special Needs/Other Type_____

Parent Signature _____ Date _____

Informed Consent
General Anesthesia

River Valley PEDIATRIC DENTAL SPECIALISTS

Patient Name: _____

Date of Birth: _____ Age_____

The staff at River Valley Pediatric Dental Specialists has consulted with me about my child's tentative treatment plan and treatment options for my child. I have been informed of the contents of a general anesthesia procedure. Risks and benefits of treatment have been discussed with me and staff has answered questions about general sedation and my child's treatment appropriately. I am aware that the treatment plan is subject to change if intra-operative radiographs reveal additional diagnostic information to the Dentist.

I give consent to have River Valley Pediatric Dental Specialist schedule the following appointments:

- History and Physical Examination (with my child's physician)_____
- General Sedations Appointment with (hospital name) _____

Parent/Guardian NAME _____

Parent/Guardian SIGNATURE: _____ Date: _____

Provider SIGNATURE: _____ Date: _____