Northern Lights Dental Anesthesia, LLC
P: (907) 268-3109 F: (907) 331-0216
www.NorthernLightsDentalAnesthesia.com
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Adult Health History Form

Name _____ Home Phone _____ Cell Phone _____

Address_____

Date of Birth_____ Weight _____ lbs Height_____ □ Male /□ Female

Name of Dentist _____ Name of Physician _____

Physician Phone _____ Date of last medical exam_____

List all medications you are taking (include vitamins, herbs, birth control pills, etc.):

_____

_____

_____

Do you have any allergies? □Yes □ No Please list allergy and reaction:_____

_____

Please circle the correct response.

1. Are you in good health? ..... Yes □ No□
2. Has there been any change in your health in the past year? ……..... Yes □ No□
3. Are you under the care of a Physician? ..... Yes □ No□
   If yes, for what condition? _____
4. Have you had any serious illness, operation or been hospitalized in the past 5 years?... Yes □ No□
   If yes, for what condition? _____
5. Are you taking any medications? Please list above. ..... Yes □ No□
6. Are you using any recreational drugs? (or other prescription drugs)…..……. Yes □ No□
   If yes, please list. _____
7. Do you have or have you had any of the following diseases or problems? ..... Yes □ No□
   A. Damaged or artificial heart valve(s), Heart murmur, Rheumatic Heart Disease? Yes □ No□
   B. Artificial joints or grafts? …… Yes □ No□
   C. Congenital heart defect(s) or murmur? ……... Yes □ No□
   D. Cardiovascular Disease: Heart Attack, Angina, Coronary Disease, High Blood Pressure or Stroke? ……..... Yes □ No□
      i) Can you walk up a flight of stairs without stopping to rest? ..... Yes □ No□
      ii) Do you get short of breath easily? …… Yes □ No□
      iii) Do your ankles swell during the day? ……..…… Yes □ No□
      iv) Do you have any heart defects or a pacemaker? ……..…… Yes □ No□
      v) Do you have any arrhythmia or irregular heart rhythm? ……... Yes □ No□
8. Has your physician ever told you to take antibiotics prior to dental visits?..... Yes □ No□

If yes, for what condition?_____

9. Do you have or have you had any of the following? Please mark all that apply.

□Asthma	□Bronchitis	□Pneumonia
□Emphysema	□Tuberculosis (TB)	□Chronic cough
□Hay Fever/Allergies	□Sinus Congestion	□Diabetes
□Persistent Diarrhea	□Recent weight loss	□Hepatitis
□Jaundice	□Liver disease	□AIDS/HIV
□FaintingSpells	□Seizures/Epilepsy	□Thyroid Problems
□Arthritis	□Painful Joints	□Ulcers
□Chronic Heartburn	□Kidney Trouble	□Swollen glands
□Low Blood Pressure	□High Blood Pressure	□Cancer
□PsychiatricProblems	□ Stiff neck	□GERD/Gastric Reflux
□Sinusitis	□Post Nasal Drip	□ Frequent Urination
□Sleep Apnea	□Limited Mouth Opening	□TMJ Disorder
□Severe "gag" reflex	□Compromised Immune System	

10. Do you currently have a cold, flu, runny nose, cough, congestion of the head or chest? Yes □ No□

11. Do you smoke cigarettes? ….....……..Yes □ No□
Packs per day?_____How many years?_____

12. Do you have a history of alcohol use and/or drug use? ..... Yes □ No□
If yes, what and when was last use:_____

13. Do you have any bleeding disorders? (i.e.Anemia, Sickle Cell, Prolonged Bleeding) .. Yes □ No□

14. Have you had surgery or radiation treatment for a tumor/cancer of your head or neck? Yes □ No□

15. Have you had general anesthesia for an operation before?..... Yes □ No□

16. Have you had any serious trouble associated with any previous dental treatment, surgery, or any previous anesthetic? …….....…….. ….....Yes □ No□
If yes, please explain:_____

17. Has anyone in your family had an adverse reaction to a previous anesthetic? ..... Yes □ No□

18. Do you snore heavily or have obstructive sleep apnea? ..... Yes □ No□

19. Do you have any condition not already mentioned (i.e Down syndrome, Autism, Developmental Disability)?

If yes, please list: _____ Yes □ No□

WOMEN

20.Are you currently pregnant? ..... Yes □ No□

21. Is there any possibility that you may be pregnant? ..... Yes □ No□

22.Are you nursing?..... Yes □ No□

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge.

Signature of Patient/Parent/Guardian _____Date_____

Reviewed by Dr. Kenley Michaud/Dr. John Leach _____Date _____

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Informed Consent for Anesthesia

Initial _____The following is provided to inform patients, and/or parents of minor children of the choices and risks involved with having dental treatment under anesthesia. This information is not presented to make patients, parents, or legal guardians more apprehensive, but to enable them to be better informed concerning their treatment. There are basically four choices for anesthesia: local anesthesia, conscious sedation, general anesthesia, and/or no anesthesia. These can be safely administered in either an office, surgery center, or hospital setting.

Initial _____The most frequent side effects of any anesthesia are drowsiness, nausea/vomiting, and phlebitis. Most patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired for as long as 24 hours. It is recommended that adults refrain from activities such as driving, and children remain in the presence of a responsible adult during this period. Nausea and vomiting following anesthesia can occur in 15-30% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however tenderness and a hard lump may be present up to a year. Nerve damage from local anesthesia administration may also be permanent.

Initial _____I have been informed and understand that on rare occasions anesthesia related complications include, but are not limited to: pain, hematoma, temporary numbness, permanent numbness, paresthesia, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and pneumonia. I further acknowledge, understand and accept the extremely remote possibility that complications may require hospitalization, and/or result in brain damage, stroke, heart attack, or death. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three choices of anesthesia, local anesthesia is usually considered to have the least risk, and general anesthesia the greatest risk.

Initial _____Since medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination, I have been advised not to use alcohol or other drugs for 24 hours. Also, I have been advised not to make any major life decisions or operate any vehicle and/or hazardous device for at least 24 hours until fully recovered from the effects of the anesthetic, medications, and drugs that have been given to me or my child. I have been advised of the necessity of direct “one-on-one” parental supervision of my child for twenty-four hours following their anesthesia. Since the patient’s memory will be impaired for 24 hours, someone other than the patient is expected to monitor and control all post operative medications.

Initial _____I hereby authorize and request **Northern Lights Dental Anesthesia, LLC** to perform the 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 or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and this is an independent function from the surgery/dentistry. I understand that Northern Lights Dental Anesthesia, LLC has no responsibility for the dental treatment to be performed, the diagnosis, or the treatment planning involved. Northern Lights Dental Anesthesia, LLC’s sole attention and responsibility will be to render the optimal and safest anesthetic. Furthermore, it is understood that the dentist anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability for the anesthesia.

Initial _____I acknowledge the pre-operative fasting regulation and will ensure they are followed. The patient has had nothing by mouth for at least eight (8) hours immediately prior to the appointment, with the exception of clear liquids, which may be taken up to two (2) hours prior to the appointment.

Initial _____I have been fully advised and completely understand the alternatives to conscious sedation and general anesthesia. I accept the possible risks, side effects, complications and consequences of anesthesia. I acknowledge the receipt of and understand both the preoperative and post-operative anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result and or cure. I have had the opportunity to ask questions about my or my child’s anesthesia, and I am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist’s procedure.

Initial _____I authorize Northern Lights Dental Anesthesia, LLC to release my information to associated parties, medical physicians, and insurance companies; in order, to provide and bill for the best possible anesthetic experience. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to 1) conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers.

Initial _____ **FEMALES:** I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Northern Lights Dental Anesthesia, LLC of the possibility of being pregnant or a confirmed pregnancy, with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother.

I have read and understand the consent for anesthesia. I have had the opportunity to have all my questions answered regarding the risks, benefits and alternatives of anesthesia.

Patient Name _____ **Date** _____

Parent/Guardian’s Name_____ **Relationship to Patient** _____

Signature_____ **Witness** _____

(Consent to be signed by patient, parent or legal guardian)

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Pre-Anesthesia Instructions

Eating or Drinking

Failure to strictly follow these instructions could result in aspiration and may be fatal. For anesthesia, it is of utmost importance that patients have an empty stomach.

No food of any kind for 8 (eight) hours prior to the appointment.

Water or Gatorade, may be taken up to 2 (two) hours prior to the appointment.

Clothing

Please wear a short sleeve loose shirt. Children should bring a blanket. For children who do not wear a diaper or pull up, please bring an extra set of clothes. Do not wear makeup, nail polish, or fake eyelashes. Contact lenses must be removed before anesthesia. Please no not bring anything valuable or wear any jewelry.

Change in health or medications

A change in health, especially the development of a cold, cough, or fever is EXTREMELY important. Please notify Dr. Michaud if there is any change in your health. Your appointment may need to be rescheduled. Prescription medications should be taken as scheduled unless previously indicated by Dr. Michaud and may be taken only with sips of water.

Designated Driver

A responsible adult must accompany any patient to the office and remain during the procedures. Do not plan on driving or making decisions for twenty-four (24) hours after the anesthesia. Arrange to have a responsible adult to spend the rest of the day with you. Young children should be in a car seat during the ride home.

Post-Anesthesia Instructions

Eating, Drinking, and Smoking

Limit oral intake to liquids for the first few hours. Begin with water and follow with sweet liquids such as sports drinks, clear juice and soda as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Suggestions include scrambled eggs, applesauce, yogurt, mashed potatoes, and soups. If your child is not hungry, do not force him/her to eat, but encourage as much liquid as tolerated. Absolutely **no alcoholic beverages** and /or **smoking** for 24 hours following anesthesia.

Activities

Do not drive and/or engage in moderate to high level physical activity for 24 hours or until the effects of the anesthetic have completely subsided. Judgment may also be impaired during this time, so please avoid making any major life decisions. For children, do not allow them to swim, bike, skate or play with other children until fully recovered. Place a blanket on the floor for the child to rest and observe him/her closely.

Pain or Fever

Muscle aches and a sore throat may occur similar to the flu following anesthesia. These symptoms are very common and will usually disappear within 24 to 36 hours. Medications such as Tylenol and Advil are usually very effective and should be taken at the first sign of pain, if normally tolerated. For children, a fever of up to 101 degrees Fahrenheit may develop for the first 2 hours. Tylenol Elixir every 3 to 4 hours with plenty of liquids will tend to alleviate this condition as well as treat any post-operative discomfort.

Seek Advice

If vomiting occurs and persists beyond 5 hours, if temperature remains elevated beyond 24 hours, or if you have other serious concerns following anesthesia, please contact: **our office at (907) 268-3109**. In the event of a serious medical emergency, please call 911.