



BAY ANESTHESIA

GROUP

THE CARE YOU NEED, WHERE YOU NEED IT

Phone (650) 282-4171

Fax (650) 282-4187

info@bayanesthesiagroup.com

www.bayanesthesiagroup.com

Medical History for Pediatric Patients

PATIENT NAME: _____ Date: _____

NAME OF DENTIST/OFFICE: _____ Appointment Date: _____

Name of person completing form: _____ Relationship to patient: _____

PAYMENT: ☐ Self Pay ☐ Medicaid State ID # _____

NAME OF LEGAL GUARDIAN: _____ Relationship to Patient: _____

Phone: _____ Email: _____

Mailing Address: _____

Primary Physician: _____ Phone: _____

Address: _____

Specialist Physician: _____ Phone: _____

Address: _____

Date of Birth: _____ Sex: ☐ MALE ☐ FEMALE

Current General Health Status: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Height: _____ feet _____ inches Weight: _____ lbs.

Pregnancy/Neonatal History

1. Were there any complications during pregnancy or delivery? _____

2. Delivery: ☐ VAGINAL ☐ C-SECTION If c-section, reason: _____

3. Was your child premature? ☐ NO ☐ YES, born at _____ weeks

4. Were there any complications during the newborn period? _____

Infancy/Childhood/Adolescence

1. Does your child have any allergies to drugs, supplements or latex? NO YES

Type of allergy: _____

Reactions: RASH HIVES EMERGENCY ROOM OTHER _____

2. Has your child ever been hospitalized? NO YES (explain) _____

3. Has your child ever had surgery? NO YES

Type and date of surgery: _____

4. Has your child ever had general anesthesia? NO YES

Any problems with anesthesia? _____

5. Has anyone in your family had problems with general anesthesia? NO YES

What problems? _____

6. List all medications, drugs and supplements your child is now taking: _____

Has your child ever been treated for, or diagnosed with, any of the following conditions?

Heart Diseases	NO	YES	WHEN	MEDICINE/TREATMENT
Heart murmur	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
Irregular heart beat	_____	_____	_____	_____
Congenital heart defect	_____	_____	_____	_____
Other heart problem	_____	_____	_____	_____

Lung Diseases	NO	YES	WHEN	MEDICINE/TREATMENT
Wheezing/bronchiolitis	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Pneumonia	_____	_____	_____	_____
Obstructive sleep apnea	_____	_____	_____	_____
Other lung problem	_____	_____	_____	_____

Other Conditions	NO	YES	WHEN	MEDICINE/TREATMENT
Diabetes	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____
Seasonal allergies/eczema	_____	_____	_____	_____
GERD/ulcer/hernia	_____	_____	_____	_____
Recurrent ear infections	_____	_____	_____	_____
Seizure disorder	_____	_____	_____	_____
Psychiatric condition	_____	_____	_____	_____
Genetic syndrome	_____	_____	_____	_____
Learning disability	_____	_____	_____	_____
Anemia	_____	_____	_____	_____

Please list any other medical conditions: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my child's treatment and treatment results. I also certify that Bay Anesthesia Group may communicate patient information using the contact information listed above.

Legal Guardian's Signature

Date



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Consent for Anesthesia Services

The following is provided to inform patients and parents about having treatment under anesthesia. The information is not presented to make you more apprehensive, but rather to enable you to better understand the risks and benefits involved with anesthetic treatment.

I hereby authorize and request any doctor represented with Bay Anesthesia Group to administer anesthesia as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for myself/my child's well-being, may be performed to supplement the planned anesthesia. It has been explained to me that all types of anesthesia, although safe, involve some risks and no guarantees can be made concerning results. Serious complications are very rare. The following are complications that may be associated with the anesthetic treatment:

Common complications:

- Pain and/or bruising at the IV site
- Sore throat and/or hoarseness
- Muscle aches
- Nausea and/or vomiting

Uncommon complications:

- Headache
- Injuries to lips or teeth from airway instruments or devices
- Unexpected drug reaction
- Infection at intravenous site and veins nearby
- Bleeding/injury in the nose due to passage of a breathing tube
- Lung infection
- Eye injury or infection
- Weakness in breathing after awakening
- Nerve damage

Rare complications:

- Heart injury
- Brain damage or death

The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your/your child's anesthesia for dental treatment, and consult with your dentist or physician as needed.

Alternative options to deep sedation/general anesthesia have been discussed with me and may include the use of local anesthesia with nitrous oxide sedation or local anesthesia alone.

All sedation and anesthesia patients must be accompanied to and from the appointment by a responsible adult. The responsible adult should remain in the office during the appointment unless authorized by the practitioner. For the safety of the patient, the responsible adult must remain in the designated waiting area during treatment time. Office staff will escort the responsible adult back to the treatment area once the anesthesiologist deems it is safe, to be present for recovery. Upon release, the patient must be driven home by the responsible adult (public transportation or cabs are not acceptable).

I confirm that myself/the patient has not had anything to eat (other than indicated medications with the smallest amount of water) for at least seven (7) hours prior to anesthesia, and only clear fluids were consumed up to two (2) hours prior to anesthesia.

I certify that to the best of my knowledge, the patient is not pregnant or trying to become pregnant.

I have read and agree to the Notice of Privacy Practices/HIPAA agreement posted on our website,
www.bayanesthesiagroup.com

I consent to the anesthesia deemed appropriate by my anesthesiologist. I acknowledge that I have read this form or had it read to me and that I understand the risks, alternatives and expected results of the anesthetic plan of care.

Patient/Legal Guardian's Signature

Date

Relationship to patient