BAY ANESTHESIA GROUP

Phone (650) 282-4171
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info@bayanesthesiagroup.com
www.bayanesthesiagroup.com

Medical History for Pediatric Patients

Patient Name: _____ Date: _____

Name of Dentist/Office:_____ Appointment Date: _____

Name of Legal Guardian: _____ Relationship to Patient: _____

Phone: _____ Text OK? YES ☐ NO ☐ Email: _____

Mailing Address:_____

Date of Birth:_____ Sex: MALE ☐ FEMALE ☐ Other ☐

Height: _____feet _____inches Weight: _____lbs. Date of Last Physical:_____

Primary Physician: _____ Phone:_____

Group/Practice:_____ City:_____

Specialist Physician:_____ Phone:_____

Pregnancy/Neonatal History

1. Was your child premature? NO ☐ YES ☐ If YES - My child was born at _____ weeks
2. Were there any complications during the pregnancy or newborn period? NO ☐ YES ☐

Explain: _____

Infancy/Childhood/Adolescence

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

Type of allergy: _____

Reactions: RASH ☐ HIVES ☐ EMERGENCY ROOM ☐ OTHER ☐ Explain: _____

4. Has your child ever been hospitalized? NO ☐ YES ☐

Explain: _____

5. Has your child ever had surgery? NO ☐ YES ☐

Type of surgery and date : _____

6. Has your child ever had general anesthesia? NO ☐ YES ☐

Were there any complications with the anesthesia? _____

Family History

7. Has anyone in your family had complications with general anesthesia? NO ☐ YES ☐

Explain: _____

8. Has anyone in your family had a history of malignant hyperthermia during surgery? NO ☐ YES ☐

Explain: _____

Medications

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?

Condition	Yes	No	If Yes, Please Provide Further Details
Heart Murmur	☐	☐	
High Blood Pressure	☐	☐	
Irregular Heart Beat	☐	☐	
Congenital Heart Defect	☐	☐	
Heart Surgery	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Obstructive Sleep Apnea	☐	☐	

Patient Name: _____

Condition	Yes	No	If Yes, Please Provide Further Details
Enlarged Tonsils	☐	☐	
Other Lung Problem	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Gerd/Ulcer	☐	☐	
Recurrent Ear Infections	☐	☐	
Recurrent Nose Bleeds	☐	☐	
Bleeding/Clotting Disorder	☐	☐	
Anemia	☐	☐	
Seizure Disorder	☐	☐	
Genetic Syndrome	☐	☐	
Down Syndrome	☐	☐	
Autism Spectrum	☐	☐	
Psychiatric Condition	☐	☐	

Please specify any additional medical conditions or symptoms your child has that are not mentioned above:

_____

_____

I hereby certify that the information provided above is complete and accurate to the best of my knowledge. I acknowledge that any incomplete or inaccurate information may adversely affect my child's treatment and its outcomes. Additionally, I authorize Bay Anesthesia Group to communicate patient information using the contact details provided.

_____

Legal Guardian's Signature Date

Patient Name: _____

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THE CARE YOU NEED, WHERE YOU NEED IT

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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 Dentist Anesthesiologist 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.

Patient Name: _____

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 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, myself/the patient is not pregnant or trying to become pregnant.

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

I consent to the anesthesia deemed appropriate by my Dentist 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 Signature or Legal Guardian's Signature (If completed on behalf of the Patient) Date

_____

Legal Guardian's Name Printed (If completed on behalf of the Patient)

_____

Legal Guardian Relationship to Patient

Patient Name: _____