Once you have completed the enclosed forms, please return them to Accessible Dental Services via the fax, e-mail, or the mailing address listed below:

Fax: (724) 772-9642
E-mail: schedule@accessibledental.org
Mailing Address:
Accessible Dental Services, Inc.
P.O. Box 189
641 Reno Street
Rochester, PA 15074

***THIS PACKET IS DUE 4 WEEKS PRIOR TO YOUR SCHEDULED IV SEDATION APPOINTMENT, TO BE REVIEWED BY THE ANESTHESIOLOGIST. IF NOT RECEIVED PRIOR TO YOUR SCHEDULED APPOINTMENT, YOUR APPOINTMENT IS SUBJECT TO BEING CANCELLED/RESCHEDULED.**

For any questions, please call or email us at:

Phone: (724) 775-0448 x3009 (Please leave a voicemail – we will return your call)
Email: schedule@accessibledental.org

PREOPERATIVE ANESTHESIA INSTRUCTIONS

You should not eat or drink anything after midnight before your scheduled surgery day. You may take all of your regularly scheduled medications in the morning on day of your operation with either a small sip of water, a tablespoon or less of clear Jell-O, or a tablespoon of Karo Syrup. **(NO APPLESAUCE, NO PUDDING, NO THICK-IT PERMITTED!)** Please contact your PCP to give you specific instructions if you are on diabetic medications or other medications which require special attention. Call with any questions.

You must make arrangements for two responsible adults to take you home after your anesthetic. **For safety reasons, you are *required* to have a responsible adult, in addition to the driver of the vehicle, to care for you and any additional patient who have been sedated and are passengers in your vehicle. This condition will be strictly enforced. You will not be allowed to leave alone or drive yourself home.**

Wear loose fitting clothing with short sleeves. Appropriate footwear: no flip-flops or open toed shoes. Contact lenses, jewelry, and nail polish must be removed prior to your operation.

What to expect the Day of Your Surgery:

You will meet your Anesthesiologist the day of your operation. Your medical history will be reviewed, and all of your questions will be answered. Your consent to proceed with your anesthetic and procedure must be completed. An Intravenous Line (IV) will be started, and appropriate monitors will be attached to you for monitoring purposes and for your safety. Your Anesthesiologist is also responsible for managing medical problems that might arise related to surgery as well as any chronic medical conditions you may have, such as asthma, diabetes, high blood pressure, or heart problems. Your anesthesiologist will remain with you during your entire procedure. When you meet appropriate discharge criteria you will be discharged. Your escorts will be allowed to be with you from this point onward. As you 'awaken' further, staff will assist you in preparing to leave for home.

Should you have any questions whatsoever, you may call our team at the numbers provided.

POST OPERATIVE ANESTHESIA INSTRUCTIONS

Should you have a **LIFE-THREATENING EMERGENCY** after your procedure, please activate your local emergency response (Call an Ambulance, Dial 911) immediately.

Nausea or vomiting may be related to anesthesia, the type of surgical procedure, or postoperative pain medications. Although less of a problem today because of improved anesthetic agents and techniques, these side effects continue to occur for some patients. Most patients are given an antiemetic to help decrease this incidence of nausea and vomiting. Most cases are quickly self-limiting. If these problems persist, please contact either your Surgeon or Anesthesiologist for further instructions.

Patients often experience drowsiness and minor after-effects following anesthesia, including muscle aches, sore throat and occasional dizziness or headaches. These side effects usually decline rapidly in the hours following surgery and anesthesia but might persist for several days before they are gone completely. The majority of patients do not feel up to their typical activities the next day, usually due to general tiredness or surgical discomfort. Plan to take it easy for a few days, until you feel back to normal. Know that a period of recovery at home is common and to be expected. Patients may make you drowsy and unable to concentrate. For the first 24 hours after your anesthetic, it is highly unadvisable to engage in activities such as driving, operating machinery, or making complex decisions.

Special Need Patients must have someone with them continually until they are back to their baseline.

This cannot be overemphasized.

PATIENT INFORMATION

PLEASE PRINT VERY CLEARLY

Patient Name: _____ Date: _____/_____/_____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____

Patient's Agency: _____ House Name: _____

Day Phone #: _____ Night Phone #: _____

Agency Contact Name: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Medical Insurance: _____
Name Subscriber # Group #

Dental Insurance: _____
Name Subscriber # Group #

Please provide a copy of insurance cards if able.

Does your insurance (Med/Dent) require a Preauthorization? Yes ☐ No ☐

Primary Care Physician: _____
Name Phone #

Address: _____
Street City State Zip Code

Authorization: I hereby authorize payment directly to Accessible Dental Services, Inc. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.
I hereby authorize Accessible Dental Services, Inc. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the anesthesia/dental medical histories are correct to the best of my knowledge. I grant the right to the dentists to release my anesthesia/dental histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature: _____ Date: _____/_____/_____

ACCESSIBLE DENTAL SERVICES INC.

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

Who is providing this information? Name: _____ Date: _____/_____/_____

Relationship to Patient: ☐ Physician ☐ Nurse ☐ House Manager ☐ Parent ☐ Patient

Patients Information: Age: _____ Height: _____ Weight: _____ lbs. Sex: Male ☐ Female ☐

Patient's Physician Name: _____ Phone Number: _____

Date of last PCP visit: _____/_____/_____ Reason: _____

Has the patient had any emergency medical treatment in the last two years: Yes ☐ No ☐
If Yes, Reason: _____
Has the patient had a serious illness or operation? Yes ☐ No ☐
List if any: _____
Has the patient experienced "trouble" with a previous anesthetic: Yes ☐ No ☐
If yes, please explain_____
Does the patient smoke? Yes ☐ No ☐ If Yes, how many packs per day and how long? _____

Has the patient had any allergies or adverse reactions to any drug or medication? Yes ☐ No ☐
If Yes, List drugs and describe reaction: _____
Does the patient require an antibiotic before dental treatment due to heart defects or artificial joint replacement?
Yes ☐ No ☐ If Yes, what is the reason for antibiotic? _____
Is the patient on any blood thinners (ex: Coumadin, Warfarin, Plavix, or Aspirin)? Yes ☐ No ☐
If Yes, List: _____
List all medications on next page (page 2) ➔
Describe Physical limitations: None ☐ Needs Assistance (i.e. walker) ☐ Non-ambulatory (wheelchair) ☐
Describe the ability to communicate: Good ☐ Somewhat verbal ☐ Non-verbal ☐
Describe the patient's ability to interact: Easily follows instructions ☐ Needs guidance ☐ Combative ☐
Does the patient tolerate injections and/or blood draw: Easily ☐ Needs guidance ☐ Combative ☐

High Blood Pressure	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Intellectual Disability	Yes ☐ No ☐
Angina/Chest Pain	Yes ☐ No ☐	COPD/Emphysema	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Irregular Heart Beat	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐	Paralysis	Yes ☐ No ☐
Dizziness/Fainting	Yes ☐ No ☐	Coughing/Wheezing	Yes ☐ No ☐	Autism	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Sleep Apnea	Yes ☐ No ☐	Downs Syndrome	Yes ☐ No ☐
Stroke/CVA	Yes ☐ No ☐	Loud Snoring	Yes ☐ No ☐	Psychiatric Disorder	Yes ☐ No ☐
Mini-Stroke/TIA	Yes ☐ No ☐	Pneumonia	Yes ☐ No ☐	Exhibits Pica (eats objects)	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Aspirates Food	Yes ☐ No ☐	Crohn's Disease	Yes ☐ No ☐
Heart Surgery	Yes ☐ No ☐	Gastric Reflux	Yes ☐ No ☐	Ulcerative Colitis	Yes ☐ No ☐
Congenital Heart Defects	Yes ☐ No ☐	Requires Oxygen	Yes ☐ No ☐	Cancer/Malignancies	Yes ☐ No ☐
Abnormal Bleeding	Yes ☐ No ☐	Breathing Treatments	Yes ☐ No ☐	Bladder/Kidney Problems	Yes ☐ No ☐
Aspirin or Blood Thinners	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Artificial Joints	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Requires Insulin	Yes ☐ No ☐	Limited neck Movement	Yes ☐ No ☐
Sickle Cell	Yes ☐ No ☐	Hyper/Hypothyroidism	Yes ☐ No ☐	Visual Impairment	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
		HIV/AIDS	Yes ☐ No ☐	Hearing Impairment (Deaf)	Yes ☐ No ☐
		TB	Yes ☐ No ☐	Eczema	Yes ☐ No ☐

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 2)

Patient Name: _____

Please list all medications:

Medication	Strength	Frequency (i.e. qid, q6h, etc.)

Please list all Diagnoses:

1.
2.
3.
4.
5.
6.
7.
8.

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 3)

Is the Patient regularly treated by the following:

- ❖ Cardiologist
- ❖ Pulmonologist
- ❖ Neurologist

If yes, please attach notes from the last visit with this packet.

Additional Medical Information:

Does the patient require a pre-sedation medication prior to IV Sedation appointments? Yes ☐ No ☐

If yes, please provide pharmacy information: _____

_____

Any Additional Information: _____

_____

_____

_____

_____

_____

_____

CONSENT FOR ANESTHESIA ADMINISTRATION

Patient Name: _____ Date:____/_____/_____

ACKNOWLEDGEMENT

I understand that I will be receiving Anesthesia and my Anesthesiologist will use their best judgement in my care providing this anesthetic. Anesthesia risks and dangers are rare but can be life threatening. Risks range from minor irritation at the insertion site of the Intravenous insertion all the way up to death. Although uncommon, adverse drug reactions, damage to the throat, teeth, vocal cords, or dental work, do rarely occur. I am aware that the practice of Anesthesia and Medicine is not an exact science and that no guarantee or assurance can be made as to the results that may occur.

I have read the above, my questions have been answered, and I consent to the Administration of Anesthesia.

_____ _____/_____/_____
Name of Parent/Guardian (Please Print Full Name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

_____
Witness Signature & Print Full Name

CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I hereby authorize the dental office to administer such medication and provide comprehensive oral rehabilitation. I understand that the treatment may include, but is not limited to the following: comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions.

I hereby certify that I am the legal guardian of the above referenced client or have otherwise been empowered to give consent on behalf of this client for dental treatment and extractions. This consent shall remain in force until unless otherwise terminated by me.

I have read the above, my questions have been answered, and I consent to Comprehensive Dental Treatment.

_____ _____/_____/_____
Name of Parent/Guardian (Please Print Full Name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

ACESSIBLE DENTAL SERVICES – PRIVATE PAY AGREEMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I have authorized Accessible Dental Services (ADS) to provide comprehensive oral treatment and/or rehabilitation for myself or for the above-named patient. I understand that the treatment and/or rehabilitation (i.e. comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions) may not be covered entirely by my, or the patient's, insurance.

I hereby certify that I am the patient, the legal guardian of the above referenced patient, or have otherwise been empowered to give consent on behalf of this patient for dental treatment and extractions. As such, I agree that ADS may bill my, or the patient's, Medicare, Medicaid/Department of Public Welfare or other third party insurance for the dental treatment provided. Billing shall be the responsibility of ADS; I will cooperate to the degree necessary to provide documentation regarding insurance coverage, as from time to time it may be necessary to secure payment from the appropriate entity.

I am the patient and/or I agree to act as guarantor for any unpaid services and/or invoices that qualify for private pay. ADS will send a consolidated statement, of 30 days, to me as the patient or designee. Payment will be due 30 days from the consolidated statement date. In the event payment is not received, ADS reserves the right to recoup private pay charges for unpaid services via utilization of a collection agency. In the event that I, or the patient, does not qualify for dental coverage through an insurance plan, I will act as guarantor, and in accordance with the No Surprises Act, ADS will charge for services per the ADS Private Pay Fee Schedule outlined below. The ADS Private Pay Fee Schedule represents a good faith estimate of the fees for the services provided to you by ADS.

ADS Private Pay Fee Schedule

Non-Sedation Services	Services will be billed per the Pennsylvania Medical Assistance Program Dental Fee Schedule published at: https://www.dhs.pa.gov/providers/Documents/Dental%20Care/Dental%20Fee%20Schedule.pdf
Sedation Services	$1,500 for necessary dental services including, but not limited to: • Diagnostic and Preventative Care • Restorations • Periodontal Scaling and Root Planning • Extractions • Professional Anesthesia

I understand that ADS offers payment plans for dental services and that failure to pay in full and/or engage in a qualifying payment plan will disqualify myself and/or the patient from scheduling for future dental appointments with ADS.

I have read, understand, and agree to, the above. My questions have been answered and intending to be legally bound hereby I consent to the Private Pay Agreement for Comprehensive Dental Treatment.

_____ _____/_____/_____

Signature of Parent/Guarantor Date

_____ _____

Printed Name Relationship to Patient (Self/Guarantor)

Patient Name: _____ Date:_____/_____/_____

COMMUNICABLE DISEASES RELEASE STATEMENT

Thank you for your continued trust in our office. Despite our careful attention to health and safety protocols, there is still a chance that you could be exposed to a communicable disease (cold, flu, COVID-19, etc.) in our office. Be assured that we are following State and Federal guidelines and recommended universal personal protection and disinfection protocols to the best of our ability to limit transmission of any disease in our office.

By signing below, you acknowledge that you accept the risk of, and consent to, treatment.

_____ _____
Name of Parent/Guardian (Please print full name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Client (please include phone number of Parent/Guardian in case of emergency)

_____
Witness Signature & Print Full Name