



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](mailto: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](mailto:schedule@accessibledental.org)

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## 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 inadvisable 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.

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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**PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 3)**

Patient Name: \_\_\_\_\_

**Is the Patient regularly treated by the following:**

- ❖ Cardiologist Yes  No 
  - Cardiologist: \_\_\_\_\_ Phone Number: \_\_\_\_\_
- ❖ Pulmonologist Yes  No 
  - Pulmonologist: \_\_\_\_\_ Phone Number: \_\_\_\_\_
- ❖ Neurologist Yes  No 
  - Neurologist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*If yes to **ANY** of the above, please attach the office notes from the last visit with this packet for the anesthesiologist to review prior to treatment.*

**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





**PRIVATE PAY AGREEMENT FOR COMPREHENSIVE DENTAL TREATMENT AND/OR REHABILITATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ACKNOWLEDGEMENT**

I hereby authorize Accessible Dental Services, Inc., (“ADS”) to provide comprehensive dental treatment and/or rehabilitation for myself, or for the above-named patient. I understand that the treatment and/or rehabilitation (including but not limited to the following: comprehensive exam, periodic exam, limited exam, x-rays and full mouth x-ray series, prophylaxis (cleaning), fluoride treatment, periodontal scaling and root planning, amalgam and composite restorations, and extractions) may include services that are not covered 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 comprehensive oral treatment and/or rehabilitation. As such, I agree that ADS may bill my, or the patient’s, Medicaid/Department of Human Services, Medicare, or other third-party insurance for the comprehensive oral treatment and/or rehabilitation 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 agree and understand that for any non-covered services, ADS may bill me and/or the legal guardian. I further agree and understand that this Acknowledgement constitutes me and/or the legal guardian being informed before the services are rendered with regards to the nature of services to be rendered, the services that may not be covered, the estimated charge for services (see Appendix A: ADS Non-Covered Service Fee Schedule), and that I will be personally responsible for payment of any non-covered services.

With regards to any non-covered services, 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 charges for non-covered 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 Appendix A: ADS Non-Covered Service Fee Schedule. Appendix A: ADS Non-Covered Service Fee Schedule represents a good faith estimate of the fees for the services provided to you by ADS.



**PRIVATE PAY AGREEMENT FOR COMPREHENSIVE DENTAL TREATMENT AND/OR REHABILITATION  
(CONTINUED)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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, 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 and/or Rehabilitation.***

\_\_\_\_\_  
Signature of Parent/Guarantor

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (Self/Guarantor)



**APPENDIX A: ADS NON-COVERED SERVICE FEE SCHEDULE**

<p><b>Non-Sedation Services</b></p>	<p>Non-covered non-sedation services will be billed per the applicable third-party insurance’s reimbursement rates. If the patient does not have insurance, services will be billed per the Pennsylvania Medical Assistance Program Dental Fee Schedule.</p> <p>For reference, the Pennsylvania Medical Assistance Program Dental Fee Schedule is published at:  <a href="https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/documents/dental-care/Dental%20Fee%20Schedule.pdf">https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/documents/dental-care/Dental%20Fee%20Schedule.pdf</a></p> <p>Common non-sedation services include:</p> <ul style="list-style-type: none"> <li>• D0120 - Periodic Evaluation</li> <li>• D0150 - Comprehensive Evaluation</li> <li>• D0220 - Intraoral Periapical Images</li> <li>• D0274 - Bitewing Four Images</li> <li>• D1110 - Prophylaxis</li> <li>• D2161 - Amalgam four or more surfaces</li> <li>• D4341 - Periodontal scaling and root planning</li> <li>• D9920 - Behavior Management</li> </ul>
<p><b>Sedation Services</b></p>	<p>Non-covered sedation services will be billed at a flat fee of \$2,000 to include all necessary dental services.</p> <p>Common sedation services include:</p> <ul style="list-style-type: none"> <li>• D0120 - Periodic Evaluation</li> <li>• D0150 - Comprehensive Evaluation</li> <li>• D0220 - Intraoral Periapical Images</li> <li>• D0274 - Bitewing Four Images</li> <li>• D1110 - Prophylaxis</li> <li>• D2161 - Amalgam four or more surfaces</li> <li>• D4341 - Periodontal scaling and root planning</li> <li>• D7140 - Extraction</li> <li>• D9920 - Behavior Management</li> <li>• D9222 - Deep sedation/general anesthesia</li> </ul>



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