CAREPOINT ANESTHESIA GROUP, LLC
A Comfortable Way To A Healthy Smile
8301 E Prentice Avenue, Suite 215
Greenwood Village, CO 80111
Phone (720) 606-4220
Fax (720) 606-4221
info@carepointanesthesia.com
www.carepointanesthesia.com

Medical History for Adult Patients

PATIENT NAME: _____ Date: _____

NAME OF DENTIST/OFFICE:_____ Appointment Date: _____

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

PAYMENT: [ ] Self Pay [ ] Medicaid State ID #_____

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.

1. Do you have allergies to any drugs, supplements or latex? YES NO
What are you allergic to? _____
Reactions RASH HIVES EMERGENCY ROOM OTHER _____

2. Do you bleed excessively after a cut or surgery? YES NO

3. Have you had general anesthesia in the past? YES NO
Any problems? _____

4. Has anyone in your family had problems with general anesthesia? YES NO
What problems? _____

5. List all medications, drugs, and supplements you are now taking: _____
_____
_____

WOMEN ONLY
Some anesthetic drugs may harm the fetus.
Are you pregnant now, or could you be? YES NO
Are you nursing? YES NO
Last menstrual period: _____

Do you have, or have you ever had, any of the following conditions?

Heart Diseases	NO	YES	WHEN	MEDICINE/TREATMENT
Heart murmur	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
Chest pain	_____	_____	_____	_____
Heart attack	_____	_____	_____	_____
Irregular heart beat	_____	_____	_____	_____
Other heart problem	_____	_____	_____	_____

Lung Diseases	NO	YES	WHEN	MEDICINE/TREATMENT
Shortness of breath	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Emphysema/Bronchitis	_____	_____	_____	_____
Obstructive Sleep Apnea	_____	_____	_____	_____
Other lung problem	_____	_____	_____	_____
Current or past smoker?	_____	_____	How many packs/day?_____	For how many years?_____

Other Conditions	NO	YES	WHEN	MEDICINE/TREATMENT
Diabetes	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____
Hepatitis/liver disease	_____	_____	_____	_____
GERD/ulcer/hernia	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Seizure disorder	_____	_____	_____	_____
Psychiatric condition	_____	_____	_____	_____
Recreational drug use	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Thyroid problems	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Muscle/joint problems	_____	_____	_____	_____

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 treatment and treatment results. I also certify that CarePoint may communicate patient information using the contact information listed above.

_____
Patient's (or legal guardian's) signature Date

Relationship to patient, if patient not legally able to give consent: _____

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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 CarePoint to administer anesthesia as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for 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

Rare complications:

- Heart injury
- Brain damage or death

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

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.

I confirm that the patient has not had anything to eat or drink (other than indicated medications with the smallest amount of water) for at least eight (8) hours prior to anesthesia.

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

I have read and agree to the HIPAA Notice of Privacy Practices posted on our website, www.carepointanesthesia.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: _____

I certify that the medical information that I have provided during this preoperative consultation is complete and accurate to the best of my knowledge. It has been reviewed with me and found to be complete. I understand that providing incomplete or inaccurate information may negatively influence the patient's treatment and treatment results.

_____

Patient/Legal Guardian's Signature Date