CAREPOINT ANESTHESIA GROUP, LLC
A Comfortable Way to A Healthy Smile

8301 East Prentice Avenue, Suite 215
Greenwood Village, CO 80111
Tel: 720-606-4220 : Fax: 720-606-4221
Email: info@carepointanesthesia.com
Website: www.carepointanesthesia.com

Medical History

ADULT

PATIENT INFORMATION:

Last Name: ____ First Name: ___________________________________

Tel/Cell: _____________________________ Email: ____

Mailing Address: ____

Name of Person Completing Form: __________________________________ Relationship to Patient: ______________

Dentist/Dental Office: ____ Phone: ________________________

Address: ____

Primary Physician: ____ Phone: ________________________

Address: ____

Specialist Physician: ____ Phone: ________________________

Address: ____

MEDICAL HISTORY:

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: ____________________________________
   ____

FOR WOMEN ONLY: Some anesthetic drugs may harm the fetus.

6. Are you pregnant now, or could you be? [ ] YES [ ] NO
7. Are you nursing? [ ] YES [ ] NO
8. When was your last menstrual period? ____________________

9. 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	______	______	______	______
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 Infection	______	______	______	______
Seizure Disorder	______	______	______	______
Psychiatric Condition	______	______	______	______
Genetic Syndrome	______	______	______	______
Learning Disability	______	______	______	______
Anemia	______	______	______	______

8. 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/Legal Guardian Signature: ______________________________ Date: ______________

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

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Consent for Anesthesia Services

ADULT

The following is provided to inform patients 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 treatments.

I, the undersigned, 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 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:

- Headaches
- Injuries to lips, teeth, mouth or throat 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 I have 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 that I am 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's/Legal Guardian Signature: ______________________________ Date: __________________

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

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's/Legal Guardian Signature: ______________________________ Date: __________________

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