MEDICAID REGISTRATION FORM

PATIENT INFORMATION:

Last Name: ____ First Name: ____________________________________

Date of Birth: ___ _______________ _ Gender: M [ ] F [ ] Weight (LBS): _______ Height: ____________

Name of Dental Office: ____ Appointment Date: ________________

RESPONSIBLE PARTY:

Name: ____ Relationship to Patient: __________________

Tel/Cell: ____________________________ Email: ____

Mailing Address: ____

PAYMENT INFORMATION: **[ ] MEDICAID ID #________________**

PRE-OPERATIVE (FASTING) GUIDELINES

Appointments **BEFORE** 11:00 AM:
- Nothing to eat after midnight the night before
- May take medication with a SMALL sip of water, 2 hours prior to anesthesia

Appointments **AFTER** 11:00 AM:
- Nothing to eat **8** hours prior to anesthesia
- May drink water, apple juice or Sprite only up until 4 hours prior to anesthesia
- May take medication with a SMALL sip of water, 2 hours prior to anesthesia

I certify that:

- **I have read and understand the fasting guidelines.**
- **CarePoint may communicate patient information using the contact information listed above.**

Parent/Legal Guardian Signature: ____ Date: ________________

8301 East Prentice Avenue, Suite 215
Greenwood Village, Colorado 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
www.carepointanesthesia.com