Great Lakes Anesthesia for Dentistry
Anesthesia care for children and adults
David R. Backus R.Ph., D.D.S.
Dentist and Anesthesiologist
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HEALTH HISTORY AND DOCUMENTATION

Patient Name: ____
Last First MI

Address: ____
Street City State Zip Code

Patient DOB: ____ /____ /____ **Age:** _____ **Weight:** _____ **Primary Phone:** (_____) ________________________

Parent/Guardian Name: ____________________________ **Alternate Phone:** (_____) ______________________

Method of Payment: ☐ Cash ☐ Credit Card ☐ Insurance ☐ Other_____________________________________

If you marked Credit Card, please complete the following Information:
Name on Card__________________________ **Type/Number**__________________________ **Exp.**_______ **3 digit code**_____

If you marked Insurance, please complete the following information:
Subscriber Name: ____
Last **First** **MI**
Insurance Name: ____________________________**Phone #** (_____) ____________________________

Member # __________________________________ **Group #** ___________________________________

I have been informed of the treatment plan and associated fees. I understand that the payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts, except when prohibited by law. I consent to the use and disclosure of any information concerning my (or my child's) health care to carry out payment activities in connection with submitted claims. I hereby authorize direct payment of the benefits to **David R. Backus D.D.S., Inc.** dba Great Lakes Anesthesia for Dentistry
Signature of Patient or Parent/Guardian __________________________________ **Date:** ______/______/_______

MEDICAL HISTORY REVIEW

Physician Name_______________________________________ **Phone Number**________________________________
Specialist Physician Name_____________________________**Phone Number**________________________________

PLEASE CHECK

YES NO

☐ ☐ Are you **ALLERGIC** to anything? Name medications and type of reactions (include latex products, sulfites and food preservatives) ____

☐ ☐ Are you taking any **MEDICATIONS**? (Include prescriptions, over the counter, vitamins, eye drops, inhalers, herbal supplements) If you need extra room, please ask for a more paper to do so.

Medication	Purpose	Dose	How Often?	Last Taken?

NOTE: IF YOU HAVE BEEN TAKING ANY ILLICIT (STREET) DRUGS, PLEASE TELL THE ANESTHESIOLOGIST. THIS IS IMPORTANT FOR YOUR SAFETY.

Complete the back side as well

PLEASE CHECK
YES NO

☐ ☐ Have you had previous surgeries? What anesthetics? (local, block, spinal, epidural, general)

SURGERY	YEAR	ANESTHESIA
______________________________	__________	___________________________
______________________________	__________	___________________________
______________________________	__________	___________________________

☐ ☐ Can you climb a flight of stairs? 0______ 1_______ 2_______ 3 or more? _________
☐ ☐ Have you ever had problems with anesthetics? (nausea, vomiting, malignant hyperthermia)
____
☐ ☐ Has anyone in your family had unusual reactions to anesthetics? _____________________

PLEASE CHECK
YES NO **PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**

☐ ☐ Irregular Heart Beat / Heart Disease / Heart Valve Disease / Mitral Valve Prolapse / Pacemaker/AICD_______
☐ ☐ Heart Attack / Angina / Chest Pain / Fainting ____
☐ ☐ High Blood Pressure____
☐ ☐ Do you have a Cold / Cough / Asthma (Wheezing)? ____________________________________
☐ ☐ Lung Disease / Difficulty Breathing / Sleep Apnea _____________________________________
☐ ☐ Tobacco use? How Much? How Long? Quit? ____
☐ ☐ Frequent Headaches / Stroke ____
☐ ☐ Nervous Disorder/ Seizures/ Neurologic Disease ____
☐ ☐ Diabetes / Thyroid Disease ____
☐ ☐ Kidney Disease / Liver Disease ____
☐ ☐ Infectious Disease (Hepatitis, HIV, TB, etc.) ____
☐ ☐ Heartburn / Gastritis / Esophageal Reflux / Hiatal Hernia / Ulcer ____________________________
☐ ☐ Drink Alcoholic Beverages? How much? ____
☐ ☐ Drug Use ____
☐ ☐ Arthritis / Autoimmune Disease ____
☐ ☐ Difficulty Opening Mouth or Moving Neck ____
☐ ☐ Dentures / Chipped Loose Teeth / Special Dental Work _______________________________
☐ ☐ Bleeding / Blood Transfusion / Bruising / Sickle Cell / Clotting Problems ______________________
☐ ☐ Contact Lenses / Glaucoma ____
☐ ☐ Female patients: Could you be pregnant? ____

IS THERE ANYTHING ELSE WE SHOULD KNOW?
____

Acknowledgement of Risks of Anesthesia

Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, complications can occur. Minor problems include nausea and vomiting, headache, and injury to vocal cords, teeth and dental work. Serious complications include nerve injury, damage to one or more of the vital organs, even major disability or death. Other complications can occur. Although major complications of anesthesia are rare in healthy people, some types of health problems increase the risk of such occurrences.

It is important that you have fully and accurately completed this "Health History and Documentation". Prior to your procedure, your anesthesiologist will talk with you in more detail as necessary. During this preoperative visit, you will be encouraged to discuss your anesthesia, the possible alternatives, as well as the risks of anesthesia mentioned above. Please ask as many questions as you feel necessary in order to assist you in making an informed decision.

Your signature on this page indicates your acknowledgement that risks and complications exist as a result of anesthesia and that all questions at this time have been asked and answered to your understanding and satisfaction.

Signature: ____ **Date:** _______/_______/________
Patient/Legal Representative

Reviewed by: ____ **Date:** _______/_______/________
Anesthesiologist Signature