

# **Bryan Horgan, DDS**

ient N	ame:	DOB:	Gender:	Age:	_ Weight:	Height:	
9.	Has the	patient ever had any health problems? $\Box$	No □ Yes	Explanation:			
10.	Has the	patient ever been hospitalized or had any	surgery(s)?	□ No □ Yes	Expla	nation:	
11.		patient, or a blood relative to the patient, tion:		action to anesthe	esia? 🗆 No	☐ Yes	
1.	·						
2.		tient being followed by a physician for a s n Name: Fax:				Date of Last Exam:	
3.	Has the	patient had a cough, cold, fever, etc. In th	e past month?	□ No □ Yes	;		
	If yes, date symptoms resolved:						
4.	Has the patient ever had any of the following cardiovascular conditions?						
	a.	Congenital Heart Defect or Murmur	□ No □ Yes				
	b.	Arrhythmia or Irregular Heart Beat	□ No □ Yes				
	C.	Chest Pain Upon Exertion/Angina	□ No □ Yes				
	d.	Shortness of Breath w/ Mild Exertion	□ No □ Yes				
	e.	Heart Surgery	□ No □ Yes				
	f.	Artificial or Damaged Heart Valve	□ No □ Yes				
	g.	Congestive Heart Failure	□ No □ Yes				
	h.	High Blood Pressure	□ No □ Yes				
	i.	Stroke or TIA	□ No □ Yes				
	 j.	Pacemaker	□ No □ Yes				
		er Heart/Blood Vessel Disorder:	_ NO _ 100				
5.		patient ever had any of the following lung	diseases?				
0.	a.						
	b.	Tuberculosis	□ No □ Yes				
		Bronchitis, Emphysema, or Pneumonia					
	C.	· ·					
	d. Oth	Cystic Fibrosis	□ No □ Yes				
6.		er Lung Disorder:patient ever had any of the following med	ical conditions?				
0.							
	a.	Liver Disease (hepatitis, jaundice)	□ No □ Yes				
	b.	Kidney Disease	□ No □ Yes				
	C.	Thyroid Disease	□ No □ Yes				
	d.	Autism or ADHD (circle which)	□ No □ Yes				
	e.	Cerebral Palsy	□ No □ Yes				
	f.	Mental Retardation	□ No □ Yes				
	g.	Down Syndrome	□ No □ Yes				
	h.	Sleep Apnea	□ No □ Yes				
	i.	Frequent Nosebleeds	□ No □ Yes				
	j.	Diabetes	□ No □ Yes				
	k.	Blood Disorder	□ No □ Yes				
	I.	Bleeding Problem	□ No □ Yes				
	m.	Arthritis	□ No □ Yes				
	n.	Cancer	$\square$ No $\square$ Yes				
	0.	Seizure Disorder/Epilepsy	□ No □ Yes				
	p.	Acid Reflux/Heartburn/GERD	□ No □ Yes				
	q.	Premature Birth	□ No □ Yes				
	r.	Muscle Weakness	□ No □ Yes				
7.	Does the	e patient have any allergies?	☐ No ☐ Yes, list	all allergies:			
8.	Does the	e patient take any medications?	□ No □ Yes, list	all medications:			



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10.	Has the patient ever been hospitalized or had any surgery(s)?			□ No □ Yes	nation:			
11.	Has the patient, or a blood relative to the patient, ever had a bad reaction to anesthesia? ☐ No ☐ Yes Explanation:							
	Name of person filling out form			Relationship to patient				
	O'matura of a	Current Control of the Control of th	<del></del>					
	Signature of parent/guardian/person filling our form			Date				

# **Informed Consent/Agreement Between Parties**

The form is intended to be written in plain English. If you do not understand any part of it, please ask for an explanation.

#### Consent for the administration of Anesthesis

I understand that one or more of the following types of anesthesia may be used: General Anesthesia, Deep Sedation, Moderate Sedation, Mild Sedation, Local Anesthesia.

Significant risks and complications of anesthesia to be administered have been explained and include but are not limited to: sore throat, nausea and vomiting, dysphoria, upper respiratory infection, bronchitis, pneumonia, broken/chipped teeth, cardiac arrhythmia, cardiac arrest, allergic reaction, and death.

It is usually necessary for intravenous access to be established for sedation. U understand that multiple attempts at multiple locations on the body may be necessary to gain this access and that these attempts may cause bruising that is unsightly and uncomfortable.

I understand that the method used to apply monitors to the patient, position the patient, and to maintain the patient's airway patent may result in red marks and/or bruising on the patient's head, face, neck, and body.

I accept these risks and hereby consent to the administration of anesthetics. No warranty or guarantee has been made as to the results thereof.

Following surgery, a responsible person will drive the patient home. I have made arrangements for this. I realize that impairment of full mental alertness and physical coordination may persist for up to 12 hours, and I will avoid making decisions or taking part in activities, which depend upon full concentration, judgment, or coordination during this period.

### **Consent to Transfer**

I understand that all procedures to be performed will be done on an outpatient basis and that 24-hour patient care will not be provided. If my dentist anesthesiologist shall find it necessary or advisable to transfer the patient to a hospital or other health care facility, I consent and authorize my dentist anesthesiologist to arrange for and affect the transfer.

I further consent to the release of patient information pertaining to medical care should admission to an acute care facility become necessary during or following treatment received by my dentist anesthesiologist. I authorize medical records from the admitting acute care facility to be released to my dentist anesthesiologist.

# Consent to Blood and/or Blood Products Transfusions

I understand that should the patient need blood or blood products, the patient will be transferred to an acute care hospital for the delivery of such.

### **Consent to Resuscitation**

This signed document implies consent for resuscitation and transfers to a higher level of care should the patient suffer a cardiac or respiratory arrest or other life-threatening situation. I am aware that my dentist anesthesiologist does not honor "Do Not Resuscitate" (DNR) orders/

## **Photographic Consent**

I consent to the use of photography (still and/or video images) of the procedures performed during the appointment.

### **Consent to Test for Blood-Borne Diseases**

I understand that it may be necessary to test the patient's blood in an effort to protect against possible transmission of blood-borne diseases/ If, for example, another person is stuck by a needle after giving an injection, I understand that the patient's blood, as well as the other person's blood, may be tested.



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11.	Has the patient, or a blood relative to the patient, ever had a bad reaction to anesthesia? ☐ No ☐ Yes Explanation:						
I have rec	tive and Postope eived and unders	erative Instructions stand the Preoperative Instructions Form ar provided by these forms.				Horgan, DDS. I agree to	
I have rea		aire the Health History Questionnaire and confi e that withholding any information could res			onnaire is accura	ate to the best of my	
	aluables/Personand that Bryan Ho	al Property rgan, DDS shall not be liable for the loss of	r damage to any mo	ney and/or valuat	oles.		
•	•	een Dental Office and Dentist Anesthesic	•	reatment.			
Certificati		nd understand this informed ConsentAgree	ement Between Part	ies and that I am	able to give lega	consent for the patient	
		Patient Name:					
	 Name of	f the Person Signing This Form		Signature			