Little Chompers Pediatric Dentistry Sedation

Welcome to the sedation process,

Your child needs sedation—what's next? I'm Julia Stevenson, the sedation coordinator here at Little Chompers Pediatric Dentistry. My goal is to help make this experience as easy and comfortable as possible. If you have any questions, I'm here to help. Here's what you need to know to ensure a smooth sedation process:

1. Information we need:
    a. Medical Insurance
    b. Sedation Paperwork
    c. Physical dated within one year (for in-office sedation only)
    d. Signed Treatment Plan
    e. Guardianship papers, if applicable

2. The sooner we receive all paperwork and physical (if required), the faster we can schedule your child's treatment. You may return paperwork by email, fax, or drop it off. (Note: physical is only required for ASA and REM sedations—not Blue Cloud.)

3. I may send you text reminders. Please respond or call with any questions.

4. On the day of sedation, follow the sedation team's eating and drinking instructions carefully to avoid rescheduling.

5. I'll call you a week before and a few days prior to confirm details—this is a good time to ask any final questions.

6. Please keep your phone nearby the day of the appointment. If an earlier time becomes available, we may offer it to you.

7. Your child may bring a comfort item, such as a small stuffed animal, to the appointment.

We're here to help you every step of the way. Please don't hesitate to reach out. I look forward to supporting you through the sedation process.

Thank you,

Julia Stevenson
Sedation Specialist and Front Desk Coordinator
Little Chompers Pediatric Dentistry
P: (913) 250-6583 | F: (877) 588-7935
Email: sedation@littlechomperspd.com

REQUEST FOR ANESTHESIA SERVICES

****THIS SECTION IS FOR REFERRING OFFICE USE ONLY****

Referring Office/Provider: _____

Scheduled Date: ____ / ____ / ____ ☐ To Be Determined

Estimated Treatment Time:
(Please Circle)
1 H 1.5 H 2 H 2.5 H
Other: _____

Referring Office: Please attach copies of the patient's medical insurance card, pre-anesthesia health history, current physical, and dental treatment plan when forwarding this form to Advanced Specialty Anesthesia.

To Patient or Parent/Guardian of Patient: Please Fill Out Remaining Information and Return Forms to the Referring Office

Patient Information:

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: ____ / ____ / ____ Sex: M / F

Home Address: _____ Preferred Language: _____

City: _____ State: _____ Zip: _____

Are you okay with receiving text messages from us regarding important information? Y / N

Cell Phone: _____ Alternate Phone: _____

- Does patient reside in a facility/nursing home? ☐ No ☐ Yes, Name/ Phone: _____
- Is this patient in Foster Care? ☐ No ☐ Yes, Case Worker Name/ Phone: _____

Parent/Guardian Information: (if patient is 18 years or younger) Relationship to Patient: _____

First Name: _____ Last Name: _____

Home Address (if different): _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Medical Health Insurance: Please Provide Referring Office with a Copy of All Medical Insurance Cards

Primary:
Insurance Company: _____
ID Number: _____ Group: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's SSN: _____

Secondary:
Insurance Company: _____
ID Number: _____ Group: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's SSN: _____

I hereby give permission to Advanced Specialty Anesthesia, LLC to leave a message regarding information relevant to anesthesia services and to discuss and request necessary medical records from any physician or facility named below.

Primary Care Physician: _____ Phone: _____
Specialist: _____ Phone: _____
Specialist: _____ Phone: _____
Hospital/Other Provider: _____ Phone: _____

Patient/Guardian Signature: _____ Date: _____
Printed Name: _____

Referring Office: Please attach copies of the patient's medical insurance card, pre-anesthesia health history, current physical, and dental treatment plan when forwarding this form to Advanced Specialty Anesthesia.

PRE-ANESTHESIA HEALTH HISTORY

Patient Name: _____ DOB: _____

Height: _____ Weight: _____

ALLERGIES: **NONE**

Please circle all that apply. If the patient has any other food and/or medication allergies, please list them in them in the section provided:

Soy Eggs Peanuts Tree Nuts Iodine Latex

Allergy	Reaction

Has the patient been prescribed an EpiPen? YES / NO

MEDICATIONS: **NONE**

List **all** medications, supplements, inhalers, and nebulizer treatments:

Medication	Reason

HOSPITALIZATIONS: **NONE**

Hospital	Date

PREVIOUS PROCEDURES WITH ANESTHESIA: **NONE**

Surgery/Procedure	Date

OTHER MEDICAL INFORMATION:

Primary Care Physician: _____

Has the patient seen a specialty provider? YES / NO

If yes, please list the provider's name, specialty, and last seen date:

Provider & Specialty: _____

Date Last Seen: _____

Has the patient visited the ER in the last 30 days YES / NO

If yes, list reason, date, and hospital visited: _____

Is there any family history of Anesthesia Complications? YES / NO

If yes, please explain: _____

SYSTEMS:

Please mark all that apply:

Cardiac (Heart) ☐ **NONE**

- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Congenital Abnormality
- ☐ Abnormal Heart Tests
- ☐ Chest Pain / Palpitations
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Coronary Artery Disease
- ☐ Heart Attack Date?: _____

Last Cardiology Visit? _____

Next Required Follow Up? _____

Stomach, Liver, Kidneys ☐ **NONE**

- ☐ Acid Reflux / GERD
- ☐ Chronic Nausea and/or Vomiting
- ☐ Hiatal Hernia
- ☐ Feeding Tube / PEG Tube
- ☐ Hepatitis A, B, or C
- ☐ Chronic Kidney Disease
- ☐ Fatty Liver Disease
- ☐ Cirrhosis of the Liver
- ☐ Other:

Neurologic (Brain) ☐ NONE

- ☐ Seizures Date of Last Seizure?: _____
- ☐ Paralysis / Muscle Weakness
- ☐ Hydrocephalus
- ☐ Fainting / Dizziness

Musculoskeletal ☐ NONE

- ☐ Cerebral Palsy
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Muscular Dystrophy
- ☐ Chronic Headaches / Migraines
- ☐ CVA / Stroke / TIA Date?: _____

Pulmonary (Lungs) ☐ NONE

- ☐ Asthma / Reactive Airway Disease
- ☐ Recent Cold / Respiratory Infection
- ☐ Bronchitis / Pneumonia (in the last 6 weeks)
- ☐ Tuberculosis
  - ☐ Latent ☐ Active
- ☐ Chronic Cough
- ☐ RSV / Croup
- ☐ COPD / Emphysema

Ears, Nose, Throat ☐ NONE

- ☐ Enlarged Tonsils / Adenoids
- ☐ Sleep Apnea (pauses or gasps in breathing during sleep)
- ☐ Recent Strep or Throat Infection
- ☐ Snoring
- ☐ Difficulty Swallowing

Endocrine ☐ NONE

- ☐ Diabetes Date of Last A1C?: _____
  Results?: _____
- ☐ Thyroid Disorder
- ☐ Adrenal Disorder
- ☐ Metabolic Disorder

Psychosocial ☐ NONE

- ☐ Developmental Delay
- ☐ Autism
- ☐ Intellectual Disability / HR
- ☐ ADD / ADHD
- ☐ Depression / Anxiety

Blood Disorders ☐ NONE

- ☐ Anemia
- ☐ Bleeding / Clotting Problems (Including Family History)
- ☐ Easy Bruising
- ☐ Sickle Cell
- ☐ HIV / AIDS
- ☐ Cancer Type?: _____
  Date of Diagnosis?: _____

Ears, Nose, Throat ☐ NONE

- ☐ Angelman Syndrome
- ☐ Fragile X
- ☐ Down Syndrome
- ☐ DiGeorge Syndrome
- ☐ Wolf-Parkinson-White Syndrome
- ☐ Turner / Klinefelter Syndrome

Are there any other diagnoses or pertinent medical information you feel we need to be aware of?
If yes, please explain: _____

I understand that withholding any information regarding my child's or my own health may compromise safety. I have carefully reviewed the medical history provided and have answered all questions truthfully and to the best of my knowledge. I hereby authorize Advanced Specialty Anesthesia to request and discuss necessary medical records with any physician or facility listed below.

Primary Care Physician: _____ Date: _____

Specialist: _____ Date: _____

Hospital/Other: _____

Parent/Guardian Signature: _____ Printed Name: _____

Date: _____ Relationship: _____