Ohio Pediatric Dental Anesthesia
Pediatric Anesthesia for Pediatric Dentistry
Phone: 330-598-1556 Fax: 330-294-4331
Web: www.OhioDentalSedation.com

Dental Office: IV Sedation Consultation Checklist

□ Parent's Information and Instructions

- Ask parent/guardian to take home and read:
  - Parent's General Information Page:
  - Parent's Information and Requirements for Safe IV Sedation Page:
  - Request and Consent for Sedation Page:
  - Parent's Information about Medical Reimbursement Page:
- Point out the website (www.OhioDentalSedation.com)
- Review the feeding instructions
- Tell them who their anesthesiologist will be.
- Let them know that the nurse or the anesthesiologist will call to discuss the IV Sedation

□ Pre-Anesthesia Medical History

- Fill in the Patient information and Dentist's name
- Please measure the patient's current **height** and **weight**
- Ask parent/guardian to complete the Pre-Anesthesia Medical History form **before leaving the office**.

□ IV Sedation Financial agreement

- Fill in the patient's name, dentist name and the Total Estimated IV Sedation Fee from the table to the right.
- Ask the parent/guardian to fill in the required credit card information and tell them that a $250 deposit is required to schedule.

Estimated Dental Procedure Time	Total Estimated IV Sedation Fee
15 min	$600
30 min	$675
45 min	$750
60 min	$825
75 min	$900
90 min	$975
105 min	$1050
120 min	$1125
135 min	$1200
150 min	$1275
165 min	$1350
180 min	$1425
195 min	$1500
210 min	$1575
225 min	$1650
240 min	$1725

□ To Schedule the Procedure

Fax the following to: **# (330)-294-4331**

1) IV Scheduling Sedation Form
2) Pre-Anesthesia Medical History
3) IV Sedation Agreement
4) IV Sedation Financial Agreement.

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Parent/Guardian General Information:

For more Information Please visit our website at (www.OhioDentalSedation.com)

Why is Sedation Important?
Most dental procedures in children are completed using local anesthesia, however very young, fearful or uncooperative children also require some sedation. Sedation is a deep sleep that insulates your child from the stress and discomfort associated with dental procedures. It is not the same as general anesthesia used in a hospital. With the young patient asleep and comfortable, your dentist can concentrate on the procedure knowing that your child's breathing, heart activity and general condition are being closely watched by the pediatric anesthesiologist.

Who is a Pediatric Anesthesiologist?
A pediatric anesthesiologist is a medical doctor who has completed specialty training in anesthesiology and extra training in anesthesia for infants and children.

How is Sedation Given?
Sedative medications are given as an intramuscular injection **(shot)** that works quickly and reliably within about 5 minutes. **Please do not tell your child about the shot.** You may hold and comfort your child until the sedative takes effect. Your child may not remember the injection or the office visit. Once in the dental procedure room blood pressure, heart and breathing monitors are placed. The intramuscular sedatives are supplemented with nitrous oxide administered by nose-mask and intravenous sedatives (IV). This allows your child's dentist enough procedure time to complete all of your child's dental treatment in one visit eliminating the need for repeat visits and sedations. **Parents are not allowed in the dental procedure room during the sedation.**

What are the Risks?
Every type of sedation has side effects. Dizziness is the most common, nausea and vomiting are rare. More serious risks are **extremely rare** but include allergic or unexpected reactions to medications. Should one of these rare reactions occur; further treatments, tests or even hospitalization may be necessary.

Costs:
The professional fees for your anesthesiologist's services are separate from your dental bill. Please note, **Payment of the estimated fee is due before the patient is treated,** and a $250 deposit is required at the time of scheduling.
Payment arrangements can be made through our office.

Insurance:
We will gladly help patients who have health insurance receive the maximum benefits provided your insurance company.

Anesthesia provided by a Board-certified pediatric anesthesiologist
A higher standard when it matters most

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Parent/Guardian Information and Requirements for a Safe I.V. Sedation:

NO FOOD, MILK OR FORMULA for 6 hours before the procedure.

Give CLEAR LIQUIDS (water, apple juice, Gatorade) until 3 hours before the scheduled procedure time.

Nothing by mouth for the last 3 hours

Failure to follow these instructions may result in delay or cancellation of your child's procedure.

- When you arrive at the dental office your child will be checked in, weighed, given an opportunity to use the restroom and you will receive pre operative care instructions.
- For your safety and your child's safety, parents are not allowed in the treatment room during IV sedation.
- You are expected to remain in the office during your child's entire procedure should the dentist or anesthesiologist need to consult with you regarding your child's care.
- Your child will need your undivided attention for the first 3—4 hours after the procedure.
- Please bring **another adult** with you to help with your child on the way home.
- Dress your child in loose comfortable clothing, including a short sleeve top. (This makes the giving shot easier)
- Bring a change of clothes (children sometimes wet themselves while asleep) and a small blanket.
- Please make arrangements for your other children.
- A child's dental treatment plan is an estimate only. Once the child is sedated and a complete oral exam or x-rays can be done, the time required may change.
- Recovery and discharge usually takes 20-30 minutes and you will receive post operative care instructions. Be prepared to stay longer if the anesthesiologist feels it is necessary for your child's safety.
- After you leave the office you will be responsible for your child's safety. Use seat belts on the way home, do not hold your child in your lap or lay your child down in the back seat. Your child's balance and coordination can be affected for 3-4 hours.

If your child develops a COLD, a COUGH, the FLU, VOMITING, DIARRHEA, a FEVER or has any change in health prior to the procedure please call Dr. Tucker's office. 330-598-1556

Keep these instructions near your phone. Dr. Tucker's office will call to discuss your child's sedation and answer your questions.

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Request and Consent for Sedation:

Please read the consent form, you will be asked to sign it on the day of the procedure.

Dental procedures can usually be accomplished without sedation. However, children who are very young, anxious, uncooperative, or require extensive dentistry with multiple appointments benefit from sedation. This type of sedation is not the same as a general anesthesia used in a hospital operating room. Rather, it is a controlled sleep that insulates the child from the stimulation of dental treatment while allowing the dentist to complete treatment in a safe and efficient manner. Your child will be deeply asleep but there is the possibility of bodily movements, therefore children are protected in a light Velcro wrap during the treatment period but will be unaware of this restraint. The type of sedative drugs and technique will be determined by the anesthesiologist who will consider the medical history, length of the dental procedure, and body weight of your child. He will discuss this with you.

Of course, all medications have side effects and associated risks. Rregardless of the experience or care and skill of the anesthesiologist complications could arise during treatment. They may include but are not limited to allergic reactions, pneumonia, and phlebitis (infection of the IV site). These risks are rare and although the anesthesiologist will do his best to protect your child from such risks he cannot completely guarantee the outcome of the sedation procedure.

Dr. Tucker has discussed with me the sedation procedure for my child. I understand that the type of sedation will be determined by Dr. Tucker including the use of alternative drugs as required during the procedure. I understand in the unlikely event that an unexpected reaction or complication should occur it may be necessary to transfer my child to a medical facility to continue necessary treatments initiated by Dr. Tucker. I have read the consent form, it has been explained to my satisfaction, and I request that my child be sedated for dental treatment.

About Dr. Moira Tucker:

Dr. Moira Tucker is certified by the American Board of Anesthesiology and subspecialty board certified in Pediatric Anesthesia. She received her medical degree from the National University of Ireland in 1992 and completed an internship there. She went on to complete an additional internship in internal medicine and a 3 year residency in Anesthesiology at The Cleveland Clinic Foundation. Additionally, she completed a pediatric anesthesia fellowship at Akron Children's Hospital.

Dr. Tucker has practiced pediatric anesthesiology in Northeast Ohio since 1998. She spent 5 years delivering anesthesia to adults and children at the Cleveland Clinic Foundation, 1 year of regional anesthesia at The Crystal Clinic, and 2 and a half years exclusively delivering pediatric anesthesia at Akron Children's Hospital.Since 2009, she is Section Head of SAFARI in the Dept.of Pediatric Anesthesia at Cleveland Clinic Childrens Hospital. She brings a wealth of experience in safely dealing with pediatric patients and is the leader of the Sedation Care Team.

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Parent/Guardian Information about Medical Insurance Reimbursement

Our services are available by request through your pediatric dental office. For your convenience, all scheduling, deposit and payment arrangements are made through your pediatric dental office. We will gladly help patients who have dental or medical insurance receive the maximum benefits provided by your insurance company.

Dr. Tucker is physician anesthesiologists, but is **not** a provider with any insurance company and does **not accept insurance assignment**. However, your medical insurance may reimburse you for all or part of Dr. Tucker's fees.

BEFORE THE PROCEDURE:

Call the Claims Department of your medical carrier and tell them about your child's planned procedure. Ask if your policy requires "**prior authorization**". If so, follow their instructions. They may require:

1) "**Statement of Medical Necessity**" completed and signed by your child's pediatric dentist and your child's physician which we can provide to you, and/or an
2) " **Estimated Statement of Anesthesiology Services**" form. Again this can be provided upon request

AFTER THE PROCEDURE:

To file for reimbursement after the procedure send the following forms to the Claims Department of your insurance carrier:

1) Fill out the Patient and Insured Information section on the **"1500 Health Insurance Claim Form"** that you will receive after the procedure.
2) Dr. Tucker's professional statement, (**Patient Copy Medical Insurance**) which includes a description of the medical services/medical codes for the anesthesia care.
3) "**Statement of Medical Necessity**" completed and signed by your child's pediatric dentist and your child's physician if required by your insurance carrier.
4) Your **receipt of payment** from the dental office.

Send your insurance carrier the originals and **keep copies for yourself** in case your claim gets misplaced.

File your claim even if your insurance carrier tells you the anesthesia services are not covered by your policy. Payments for services may be applied to reduce your annual deductible.

Should your insurance carrier send your reimbursement check to our office we will send you a refund check.

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I.V. Sedation / Procedure Scheduling

From the Dental Office of: _____

1. Please fill out this form and fax it to Dr. Tucker's office (330-294-4331) with the **Pre-Anesthesia Medical History,** the **Sedation** and **Financial Agreement** documents.

2. Give the patient Dr. Tucker's **Brochure,** Patient **Information** and **Instructions**, **Consent** form and **Medical Reimbursement** forms.

3. Dr. Tucker's office will call the patient soon to discuss the procedure.

Procedure Date:_____Time:_____Est. Length: _____

Patient's Name: _____

Phone: Home ( ) _____

Mom Work ( )_____Cell ( ) _____

Dad Work ( )_____Cell ( ) _____

COMMENTS:

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Pre-Anesthesia Medical History

Patient's Name	Age	Date of Birth
Parent's Name	Child's height "	Child's weight #
Home # ( )	Work # ( )	Cell # ( )
Dentist:	Estimated Dental Procedure Time:	Procedure Date:

Please check a response for each question	Y	N
Please list all medications your child is taking.		
Does anyone smoke in your child's home or daycare?		
Has your child had a history of any of the following?		
Allergies to latex, rubber, tape, eggs, food, penicillin or sulfa or any other drug allergy		
Recent cold or a cough		
Persistent cough or coughing with sleep or exercise		
Snoring, asthma, lung or breathing problems		
Heart trouble, murmur, or heart surgery		
Surgery or hospitalizations		
Problems or complications with anesthesia		
Hemophilia, bleeding problems or blood disorder		
Sickle cell anemia		
Hepatitis or liver problems		
Feeding, swallowing or digestive problems		
Kidney infection or kidney problems		
Diabetes, thyroid or hormone problems		
Cancer, tumor or leukemia		
Epilepsy, seizures or fainting		
Prematurity or other birth problems		
Cleft lip / Cleft palate or other birth defect		
Cerebral palsy, developmental delay, autism or ADHD		
Vision, speech or hearing problems		
Emotional, psychological or violent behavioral problems		
Any other medical conditions?		
I have received the IV Sedation Information papers.		
I have reviewed the anesthesia website ***pediatricsedation.com***		

Please comment on all yes responses

Child's Pediatrician: Phone # ( ) Date of last visit:

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence.

X_____

Signature of parent or guardian Today's Date

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Parent/Guardian Sedation Agreement:

Child's Name_____ **Date**_____

Please read and initial each statement:

_____For your safety and your child's safety, parents are not allowed in the treatment room during IV sedation. If you are not comfortable with this policy please ask about other care options.

_____ Your child needs your supervision and your attention for the entire day. Do not delegate supervision to baby sitters, teachers, day care or others who may not fully understand or be completely committed to your child's care needs.

_____Do not bring other children. Please make arrangements for the needs of your other children.

_____You are expected to remain in the office during your child's entire procedure should the dentist or anesthesiologist need to consult with you regarding your child's care.

_____ Last minute cancellations are an inconvenience to you, your child, the dental office and the anesthesiologist. If your child develops a cough, a cold, the flu, vomiting, diarrhea, a fever or has any change in health prior to the procedure, please call 330-598-1556 immediately.

_____A child's dental treatment plan is an estimate only. Once the child is sedated and a complete oral exam or x-rays can be done, the time required for a procedure may change.

_____Time changes in earlier procedures may affect your child's appointment time. On the day of your child's procedure you may be asked to come in earlier or later. Please be available by telephone so the dental office can contact you regarding changes to your child's appointment time. Please be flexible, do not make other appointments or commitments on the day of your child's procedure.

_____Please arrive 30 minutes prior to your child's appointment time. During this time your child will be checked in, weighed, given an opportunity to use the restroom, and you will receive post operative instructions.

_____Recovery and discharge usually takes 30-60 minutes. Be prepared to stay longer if the anesthesiologist feels it is necessary for your child's safety.

_____After you leave the office you will be responsible for your child's safety. Use seat belts on the way home, do not hold your child in your lap or lay your child down in the back seat. Your child's balance and coordination can be affected for 3-4 hours. On arrival home put your child to bed for 3-4 hours; this will protect your child from falls and bumps.
Bring another adult to help you.

I have read and understand the above information and will comply with the requirements for a safe and successful IV sedation appointment.

_____ _____
Signature of parent/guardian Dated

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IV Sedation Financial Agreement:

_____ $_____
Patient's Name **Estimated IV Sedation Fee**

Ohio Pediatric Dental Anesthesia (OPDA) Payment Policy: (Read and initial each statement)

_____ A deposit of $250 is due at the time of scheduling.

Ohio Pediatric Dental Anesthesia (OPDA) Financial agreement: (Read and initial each statement)

_____ I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services rendered by OPDA. I understand that due to the individual needs of each patient **this fee is only an estimate**. Payment for anesthesia services are based on the actual time required for completion of the dental care plan.

_____ OPDA as an **out of network provider** may file a claim for payment with my insurance company as a courtesy to me.

_____ I am aware that my health plan may impose a limit on balance billing by non-participating providers. I wish to **waive any limit on balance billing** and receive treatment from this non-participating provider (OPDA).

_____ **Assignment of benefits:** I hereby authorize OPDA to release medical information necessary to obtain payment. I will notify OPDA immediately upon any change in my insurance.

_____ **Credit / Debit Card on File:** I agree to provide a valid credit/debit card to be retained on file to pay any balance owed for my anesthesia services. **If the anesthesia services final bill exceeds the amount of the estimate an additional charge to my credit or debit card will be made. Overpayments will be credited to my card.**

Exact name as it appears on credit/debit card: _____

Circle Card Type: VISA M/C AMEX DISC Card No: _____

Expiration Date:_____/_____ *Security code #_____

[*Visa & MasterCard Security code number appears as a 3 digit number on the back of the card.
American Express Security code number appears as a 4 digit number printed on the front of the credit card above and to the right of the card number]

Card holder's address_____
Address City State zip code

Deposit required at scheduling: $ 250.00.
I understand that I am financially responsible for all charges. I hereby authorize OPDA to charge my credit/debit card for payment of the medical services rendered.

_____
Cardholder's Signature Today's Date