Pre-Operative Health Screen

SmileMD

Your practice has partnered with SmileMD to provide anesthesia for your upcoming dental procedure. Please complete this form so our Physicians may plan your anesthetic accordingly. A member of the SmileMD team will attempt to contact you prior to the procedure to discuss the anesthetic. If you do not receive a pre-op call, you will have an opportunity to discuss the anesthetic before your procedure.

Today's Date: _____

Name of Dental Practice: _____

PATIENT INFORMATION:

Patient Full Name: _____ **Parent/Guardian Name:** _____

Patient Date of Birth: _____ **Patient's Age:** _____

Parent/Guardian Phone Number: _____ **Gender:** Male ☐ Female ☐

If female could you possibly be pregnant: Yes ▫ No ▫

Height: ____' _____" **Weight:** _____

Patient's Address:

_____

Street City State Zip Code

Insurance Name: _____ **Self Pay** ☐

Insurance ID Number: _____

Born Premature? Yes ▫ No ▫

If yes, please explain:

_____

_____

Are you currently taking any medications? Yes ▫ No ▫ **Any use of an inhaler?** Yes ▫ No ▫

If yes, please list all medications and dosage down below:

_____

_____

Recent Cough/Cold/Fever? Yes ▫ No ▫

Allergies:

▫ No known allergies ▫ Medication allergies ▫ Latex allergy/sensitivity

Explain Allergies: _____

Any Previous surgical or non-invasive procedures requiring anesthesia or sedation? Yes ▫ No ▫

List Prior Procedures and dates:

_____

Any complications or concern with prior anesthetics:

_____

_____

Other Special Needs:

_____

_____

Has your child had any history of:

Heart Disease.....Yes ▫ No ▫
Hypertension..... Yes ▫ No ▫
Heart Murmur..... Yes ▫ No ▫
Atrial Fibrillation..... Yes ▫ No ▫
Asthma..... Yes ▫ No ▫
Sleep Apnea.....Yes ▫ No ▫
Snoring.....Yes ▫ No ▫
Bleeding or Clotting Problems.....Yes ▫ No ▫
Anemia.....Yes ▫ No ▫
Sickle Cell/Trait.....Yes ▫ No ▫
AIDS/HIV.....Yes ▫ No ▫
Hepatitis .....Yes ▫ No ▫

Autism.....Yes ▫ No ▫
ADD/ADHD.....Yes ▫ No ▫
Lung Disease.....Yes ▫ No ▫
Epilepsy/Seizures.....Yes ▫ No ▫
Acid Reflux/Hiatal Hernia.....Yes ▫ No ▫
Kidney/Liver Problem .....Yes ▫ No ▫
Thyroid Disease.....Yes ▫ No ▫
Diabetes.....Yes ▫ No ▫
Muscular Dystrophy.....Yes ▫ No ▫
Cancer.....Yes ▫ No ▫
Back/Neck problems.....Yes ▫ No ▫
Joint Problems.....Yes ▫ No ▫

Recent (within past 4 weeks) pneumonia/bronchitis/respiratory infection.....Yes ▫ No ▫
Pre-existing pains, numbness or weakness in arms or legs.....Yes ▫ No ▫
Family History of Sickle Cell Disease.....Yes ▫ No ▫
Family History of Tobacco Use.....Yes ▫ No ▫
Family History of Anesthesia Complications.....Yes ▫ No ▫

Describe any medical problems not listed on the medical history above:

_____

_____

By signing this I have read and understand the Pre/Post Operative Instructions and also understand and authorize SmileMD Inc. to bill my Insurance policy for Anesthesia care provided.

Patient (if 18+ years old) or Parent/Guardian Signature: _____

For Dental & Office Use Only

Reason for Sedation:

- ▫ Mildly invasive/painful procedure
- ▫ Severe Anxiety
- ▫ Autism Spectrum Disorder
- ▫ Prior Failed Attempt at Medically Necessary Dental Procedure
- ▫ Other _____

Planned Treatment:(list amount of extractions, crowns, pulpotomy, or X-rays needed)

_____

_____