Instructions for Pediatric Anesthesia

Please read the following instructions regarding your child's special appointment for dental treatment with general anesthesia. In order to ensure the best care possible, your dentist has requested that a dentist anesthesiologist assist them in general anesthesia cases.

Required Steps: Following these instructions exactly will allow us to provide the safest care possible.

1) **Download and print the required paperwork** from: www.sleeptosmile.com/forms-for-sedation/ This paperwork can be found on the "download forms" tab on our website. Your dental office may also provide a printed copy for you.

2) **Fill out the confidential pre-anesthesia health history.** This information is very important and allows us to develop an anesthesia plan that is best for your child's needs. Please print clearly and fill out the health history as completely and accurately as possible as this information is necessary to ensure the safety of your child.

3) **Fill out the informed consent and records release for anesthesia.** This allows us to collect more information from your pediatrician, primary care physician, or specialist if more information is deemed necessary.

4) **Fill out the financial agreement.** Please review the estimated fee based on the amount of time your dentist estimates dental treatment to take. All major credit cards are accepted and any special arrangements must be made in advance. Please do not hesitate to contact us for an estimate and any explanation of fees.

5) **Return the above paperwork to us.** You may send the paperwork directly by emailing the form to david@sleeptosmile.com or fax the paperwork to (916) 560-7884. You may also give the completed paperwork to your dental office with instructions to forward to Dr. Westerhaus.

6) **Consultation with Physician**. It is necessary to consult with the patient's pediatrician or primary care physician to evaluate the patient for any health issues the patient may have. This is to ensure the patient is as healthy as possible for surgery. There is a form for the physician to fill out "Pre-Anesthesia Medical Evaluation Form" at www.sleeptosmile.com/forms-for-sedation/

7) **Review of Paperwork.** Once Dr. Westerhaus has reviewed the completed paperwork, you will be contacted by telephone several days before your appointment to review the health history. Specific instructions for your appointment will be reviewed during this phone call. If you have any questions or concerns, do not hesitate to call Dr. Westerhaus at (916) 827-0046.

Financial Information: Once your health history has been reviewed, a deposit will be collected. A deposit for $600 for the first hour of anesthesia will be charged to your account. This is non-refundable and will hold your appointment time. The remaining balance is due on the day of treatment. Anesthesia billing is calculated on the total anesthesia time. This includes induction of anesthesia, surgery time, and recovery. It can be difficult to estimate anesthesia cost due to the variability of surgery time and complexity. Therefore, the balance of the anesthesia fee will be calculated and collected at the end of the procedure.

Other Important Information: Please read the following instructions and follow them exactly. Violation of any of these instructions or any other instructions from the anesthesiologist may result in cancellation of your appointment and forfeiture of your deposit.

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Instructions for Pediatric Anesthesia

Preoperative Instructions

Dr. Westerhaus is committed to providing a safe general anesthetic for your child. Please read the following carefully. It is essential to follow these instructions for the safety of your child. Please sign at the end of the document that you understand and have followed these guidelines.

Adult Escort: A responsible adult must accompany the patient to the office and remain there during the procedure and escort the patient home after the patient has met discharge criteria. Also, a responsible adult must stay with the child for the rest of the day.

Clothing: A loose fitting, short-sleeved shirt is appropriate for the appointment. If the weather is cold, please dress the patient in layers to keep warm. Cold extremities result in small veins that make it difficult to start an intravenous line. Please bring a clean older blanket that will be used to keep your child warm during the procedure. If appropriate, have your child wear a diaper and bring an extra one. Please remove any makeup on the day of surgery, including nail polish as this affects the reliability of certain monitors. Please remove anything valuable including any jewelry.

Eating / Drinking: It is extremely important that patients undergoing general anesthesia have an empty stomach on the day of treatment. Vomiting and subsequent aspiration of stomach content during anesthesia may be life threatening. In the case of a child, an adult must supervise the child constantly on the day of the appointment. The child must stay home from school. In most cases, violation of fasting guidelines necessitates rescheduling for another day.

No food of any kind for 8 (eight) hours prior to the appointment.

Clear liquids (no pulp) i.e. water, apple juice, Gatorade, may be taken up to 2 (two) hours prior to the appointment.

Illness: A change in health, especially the development of a cold, cough, nausea, or fever is EXTREMELY important. Please notify Dr. Westerhaus at (916) 827-0046 if there is any change in your health. In most cases, your appointment may need to be rescheduled in 2 - 4 weeks.

Medications: If your child takes any prescribed medications, Dr. Westerhaus will discuss with you whether or not this medication should be continued. Most medications should be taken on the day of surgery. Oral medications should be taken with a couple of teaspoons of water at least 2 hours before the appointment. Nebulized or inhaled medications should be taken as directed on the day of surgery without concern.

Pregnancy: Animal studies have shown that general anesthetic medications and radiation (x-rays) exposure during procedures have resulted in brain cell death. Therefore, general anesthesia is to be avoided during pregnancy for elective procedures. Dr. Westerhaus requests that you inform him of the potential for pregnancy on the anesthesia medical history form. Dr. Westerhaus strongly recommends pregnancy testing before the appointment if there is a risk of pregnancy.

_____ _____

Signature of Patient or Patient's Representative Date

Instructions for Pediatric Anesthesia

Day of Appointment

On the day of appointment, please arrive 15-30 minutes early. Dr. Westerhaus will review the medical history, confirm that fasting guidelines have been adhered to, and review the risks, benefits, and alternatives to general anesthesia. After answering all questions, taking preoperative vitals (including weight), and completing a physical exam (heart, lung, and airway assessment), induction of general anesthesia is initiated.

The induction of anesthesia in younger children is usually accomplished by an intramuscular injection (upper arm) of medication that will result in the rapid onset of unconsciousness. Once the patient is asleep, the child will be taken to the treatment room where monitors will be applied and an intravenous line will be placed. Your child will not feel or remember the placement of the intravenous line. Older children usually accept the placement of an intravenous catheter without undue anxiety. Your child will be able to go home when all postoperative vitals such as room air oxygen levels and blood pressure have returned to near normal baseline values and the patient is able to follow commands.

Postoperative Instructions

Eating and Drinking: Limit oral intake to liquids for the first few hours. Begin with water and follow with sweet liquids such as sports drinks, clear juice and soda as tolerated. If teeth were extracted, do not use a straw. Food can be consumed following liquids as tolerated. Suggestions include scrambled eggs, applesauce, yogurt, mashed potatoes, and soups. If your child is not hungry, do not force him/her to eat, but encourage as much liquid as tolerated.

Activities: Do not allow your child to swim, bike, skate or play until the following day. Go with them to the restroom to ensure they do not fall and hit their head. Observe them closely throughout the day. Place a blanket on the floor for them to sleep and rest so that they do not fall off their bed or the couch.

Pain or Fever: Muscle aches and a sore throat may occur similar to the flu following anesthesia. These symptoms are very common and will usually disappear within 24 to 36 hours. Medications such as over the counter Children's Tylenol and Children's Advil are usually very effective and should be taken at the first sign of pain, if normally tolerated. For children, a fever of up to 101 degrees Fahrenheit may develop for the first l2 hours. Tylenol Elixir for children every with plenty of liquids will tend to alleviate this condition as well as treat any postoperative discomfort.

Seek Advice: If vomiting occurs and persists beyond 8 hours, if temperature remains elevated beyond 24 hours, or if you have other serious concerns following anesthesia, please contact: Dr. Westerhaus on his cell phone anytime at (916) 827-0046. In the event of a serious medical emergency, please call 911.

_____ _____

Signature of Patient or Patient's Representative Date

David Westerhaus DDS INC **www.sleeptosmile.com**

Pre-Anesthesia Health History Questionnaire (Confidential)

Patient Name: _____ Today's Date: _____

Please fill out Patient Information Below: Gender: M F **Name of Dental Office:** _____

Date of Birth: ____ /____ /_____ Age: _____ Height:_____ Weight:_____ Contact Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip:_____

Name of person responsible for patient:_____ Relationship:_____ Drivers License #:_____

Address: _____ City: _____ State: _____ Zip:_____

Email: _____ Cell Phone #: (_____) _____-_____ Home Phone #: (_____) _____-_____

Doctors:

Patient's Primary Care Physician or Pediatrician: _____ Phone #: (_____) _____-_____

Date of last physical exam/ Checkup: _____ Fax #: (_____) _____-_____

Names of other Physicians/ Specialists seen: _____ Phone #: (_____) _____-_____

Date of Last Visit: _____ Type(s) of Specialist:_____ Fax #: (_____) _____-_____

Health History:

Date Patient was Last Sick:_____ (Circle any Symptoms:) Cough, Cold, Fever, Runny Nose, Sore Throat, Ear Infection

Please list any other Symptoms:_____

Have you (has the patient) ever been to the emergency room? . .Yes No For What Reason _____

Have you (has the patient) ever been in the hospital? . . . . . Yes No For What Reason _____

Have you (has the patient) ever had surgery or anesthesia?. . . . . Yes No For What Reason _____

Patient's Medical History: Please circle the appropriate response for the following questions:

Heart/Blood Vessels

Heart murmur…….	Yes	No
Congenital heart defect……..	Yes	No
Artificial heart valve…….	Yes	No
Rheumatic fever…….	Yes	No
Rheumatic heart disease…….	Yes	No
Heart valve damage……	Yes	No
High blood pressure…….	Yes	No
Heart attack…….	Yes	No
TIA / Stroke…….	Yes	No
Heart surgery…….	Yes	No
Angioplasty…….	Yes	No
Vascular surgery…….	Yes	No
Pacemaker…….	Yes	No
Coronary heart disease…….	Yes	No
Congestive heart failure…….	Yes	No
Angina pectoris…….	Yes	No
Chest pain……	Yes	No
Irregular heartbeat…….	Yes	No
Rapid heartbeat…….	Yes	No
Other heart / vessel disorder.	Yes	No

Blood

Blood clots or thrombosis…	Yes	No
Anemia……	Yes	No
Sickle cell disease / trait……	Yes	No
Hemophilia……	Yes	No
Bleeding disorder……	Yes	No
Bruise easily for no apparent reason……	Yes	No
Other blood disorder……	Yes	No

If yes, what type: _____

Nervous System

Epilepsy……..	Yes	No
Seizure disorder…….	Yes	No
Multiple sclerosis……..	Yes	No
Trigeminal neuralgia……..…	Yes	No
Chronic pain……..	Yes	No
Anxiety/depression……..	Yes	No
Alzheimer's disease……..	Yes	No
Dementia……	Yes	No
Psychiatric treatment……..	Yes	No
Psychological counseling…..	Yes	No
Persistent numbness/tingling.	Yes	No
Other nervous system disorder.	Yes	No

Head & Neck

Glaucoma……..……..	Yes	No
Chronic sinusitis……	Yes	No
Injury to head, neck, face, or teeth……	Yes	No
Headaches……..	Yes	No
Unexplained visual change…	Yes	No
Frequent or severe nosebleeds……..……..	Yes	No
Persistent sore throat or hoarseness……..……..	Yes	No
Difficulty swallowing…..…..	Yes	No
Other head / neck disorder.....	Yes	No

Endocrine

Diabetes Type I or II……..	Yes	No
Low thyroid……..	Yes	No
Other thyroid condition……..	Yes	No
Cushing's syndrome……..	Yes	No
Parathyroid condition..……..	Yes	No
Pituitary condition……..	Yes	No
Other endocrine condition…..	Yes	No

Musculoskeletal

Sjogren's syndrome……..	Yes	No
Arthritis……..	Yes	No
Artificial joint……..	Yes	No
Fibromyalgia/ rheumatitis...	Yes	No
Chronic back pain……..	Yes	No
Other bone/muscle disorder...	Yes	No

Respiratory

Tuberculosis……..	Yes	No
Asthma……..	Yes	No
Bronchitis……..	Yes	No
Pneumonia…….	Yes	No
Emphysema……..……..	Yes	No
Cough up bloody sputum…..	Yes	No
Shortness of breath……..…..	Yes	No
Wheezing……..……..…….	Yes	No
Loud snoring	Yes	No
Had a sleep study	Yes	No
Sleep apnea…….	Yes	No
Other respiratory……..……..	Yes	No

Urinary Tract

Kidney disease……..……..	Yes	No
Renal dialysis……...……..	Yes	No
Venereal disease……..……..	Yes	No
Sexually transmitted disease..	Yes	No
Urinary Tract Infection (UTI)	Yes	No
Other urinary disorder……..	Yes	No

David Westerhaus DDS INC **www.sleeptosmile.com**

Pre-Anesthesia Health History Questionnaire (Confidential)

Patient Name: _____ Today's Date: _____

Digestive System

Hepatitis	Yes	No
Liver disease	Yes	No
Cirrhosis of the liver	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Frequent heartburn	Yes	No
GERD	Yes	No
Acid reflux	Yes	No
Frequent nausea/vomiting	Yes	No
Postoperative nausea/ vomiting	Yes	No
Other digestive disorder	Yes	No

Cancer History

Leukemia	Yes	No
Benign tumors/growths	Yes	No
Cancer	Yes	No

If yes, what type: _____
If yes, treatment:
[ ] Surgery
[ ] Radiation
[ ] Chemotherapy
[ ] Hormone therapy

Other cancer	Yes	No

Skin History

Any burns to skin?	Yes	No

If so, where?_____

Eczema	Yes	No
Other skin disorder?	Yes	No
Current cuts or bruises?	Yes	No

If so, where?_____

Allergy History

Are you allergic to or have you ever had a bad reaction to the following:

Dental anesthetics	Yes	No
Penicillin	Yes	No
Sulfa drugs	Yes	No
Other antibiotics	Yes	No
Aspirin	Yes	No
Latex products	Yes	No
Metals / jewelry	Yes	No
Other allergy	Yes	No

Family History

Has anyone in your family (grandparents, parents, siblings, children) ever had:

Problems with anesthesia	Yes	No
Malignant Hyperthermia?	Yes	No
Diabetes?	Yes	No
Heart disease?	Yes	No
Depression/anxiety?	Yes	No
Tuberculosis?	Yes	No
Bleeding disorder?	Yes	No
Sudden unexplained death	Yes	No
Anything else that runs in the family?	Yes	No

If yes, what?_____

Miscellaneous

Lupus erythematosus	Yes	No
Organ transplant	Yes	No
Suppressed immune system	Yes	No
Taken steroids	Yes	No
Taken prednisone / cortisone	Yes	No
Taken prescription diet pills	Yes	No

Use/used tobacco products	Yes	No
Smoke	Yes	No
Used Marijuana	Yes	No
Chew tobacco	Yes	No
Drink alcoholic beverages	Yes	No

If yes, how much_____

Used methamphetamines	Yes	No
Used amphetamine or speed	Yes	No
Used cocaine or "crack"	Yes	No
Used other recreational drug	Yes	No
Are you a recovering alcoholic or addict?	Yes	No

Other

Down syndrome	Yes	No
Developmental delay	Yes	No
Mental retardation	Yes	No
Cerebral palsy	Yes	No
Autism	Yes	No
ADHD	Yes	No
Combative / aggressive	Yes	No
Self-abusive	Yes	No
Surgical:		
VP shunt or revisions	Yes	No
Vagal nerve stimulator	Yes	No
Blood transfusion	Yes	No

Women Only

Are you pregnant?	Yes	No
Is there a chance you could be pregnant?	Yes	No
Are you nursing (breast-feeding)?	Yes	No

Circle the following drugs that you are (the patient is) taking or have taken		
Heart pills	Oral contraceptive	Antibiotics
Nitroglycerin	Steroids/Cortisone	Antihistamines
Digitals	Hormones	Cyclosporine A
Aspirin	Insulin	Tranquilizers
Blood thinners	Diabetic drugs	Sleeping pills
Blood pressure	Thyroid	Antidepressants

List all medications and doses that the patient has been prescribed:

_____

_____

_____

_____

_____

The information on this questionnaire is accurate to the best of my knowledge and withholding any information can result in injury and death. I understand that this information will be held in strictest of confidence and it is my responsibility to inform Dr Westerhaus of any changes in this patient's medical status at the earliest possible time.

Name of person filling out form (Print): _____ Signature: _____

Relationship to patient: _____ If you are not the patient, are you able to give legal consent for the patient? . . . Yes No

Reviewed by Dr Westerhaus: _____ Date: _____

Informed Consent and Records Release for General Anesthesia

Patient Name: _____ Today's Date: _____

The following is provided to inform patients of the choices and risks involved with having treatment under anesthesia. This information is not presented to make patients more apprehensive but to enable them to be better informed concerning their treatment. There are basically six choices for anesthesia: 1) Local anesthesia 2) Minimal sedation 3) Moderate sedation 4) Deep sedation 5) General anesthesia or 6) No anesthesia. These can be administered in different settings depending on each individual patient's medical status or needs.

In the case of a minor: "The administration and monitoring of deep sedation or general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for their dental treatment, and consult with your dentist, family physician, or pediatrician as needed."

The most frequent side effects of any intravenous infusion are drowsiness, nausea and vomiting, and phlebitis. Most patients remain drowsy or sleepy following their surgery for as long as 24 hours. As a result, coordination and judgment will be impaired. It is recommended that adults refrain from activities such as driving and children remain in the presence of a responsible adult. Nausea and vomiting following anesthesia will occur in 15-30% of patients. Phlebitis is a raised, tender, hardened, inflammatory response at the intravenous site. The inflammation usually resolves with local application of warm moist heat; however tenderness and a hard lump may be present up to a year or longer.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination that can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least twenty-four hours, or until fully recovered from the effects of the anesthetic, medications, and drugs. I have been advised not to make any major decisions until after full recovery from anesthesia. Parents are advised of the necessity of direct parental supervision of their child for at least twenty-four hours following anesthesia. Limit your child's participation in moderate or heavy physical activity and monitor them closely. Children should not swim, bike, skate, etc… until fully recovered from the effects of the anesthesia medications.

I have been informed and understand that occasionally there are complications of the drugs and anesthesia including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, airway fire, pneumonia, stroke, brain damage, or heart attack. There are also unknown risks associated with anesthesia. I further understand and accept the risk that complications may require hospitalization and may even result in death. I have been made aware that the use and risks associated with local anesthesia, minimal sedation, moderate sedation, deep sedation, and general anesthesia will vary. Of these, local anesthesia is usually considered to have the least risk and general anesthesia the greatest risk. However, it must be noted that local anesthesia sometimes is not appropriate for every patient and every procedure. Nerve damage from local anesthesia administration usually resolves, however, this may take over one year to heal. Nerve damage from local anesthesia administration may also be permanent.

Potential Benefits: Advantages of general anesthesia include the following: 1) Stress and anxiety are greatly reduced and often there is no memory of the dental treatment. 2) Allows complete stillness of the patient over prolonged periods of time. 3) Pain is lessened or eliminated during the dental treatment. 4) Allows complete control of airway, breathing, and circulation.

Alternatives to Dental Treatment Under General Anesthesia:

1) If the individual can tolerate it and it relieves the patient's anxiety or pain, another level of anesthesia may be used.
2) Do not perform any recommended dental treatment. This involves risks such as infection, pain from decayed teeth and potential damage to underlying permanent teeth.
3) An oral surgeon can extract teeth that are severely decayed with or without sedation/ general anesthesia.

Females: I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant or a confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reason, I understand that I must inform the anesthesiologist if I am a nursing mother.

_____ _____

Signature of Patient's Legal Representative Date

Informed Consent and Records Release for General Anesthesia

Patient Name: _____ Today's Date: _____

Records Release: I request that my physicians and/or their agents release to Dr. David Westerhaus and/or his agents any information desired regarding my diagnosis, treatment, prognosis and recommendations as well as any other data pertinent to my surgery and anesthetic management. I also authorize Dr. David Westerhaus to speak with my spouse, parents, guardian, and/or children regarding any phase of treatment.

Fasting Guidelines: I acknowledge the pre-operative fasting regulations and have ensured that they are followed. These fasting regulations are: the patient will have nothing to eat or drink for at least 8 hours before the appointment. These restrictions are mandatory for the safety of the patient. The patient, if a minor, must be under the direct supervision of a parent or guardian during the entire fasting period. The appointment will be cancelled if these guidelines are not followed.

Informed Consent for General Anesthesia: I hereby authorize and request David Westerhaus DDS to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (local to general) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia, and that this is an independent function from the surgery/dentistry.

I have been advised of and completely understand the risks, benefits and alternatives of local anesthesia, sedation and general anesthesia. I accept the possible risks and dangers. I acknowledge the receipt of and understand both the preoperative and postoperative anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result and/or cure. I have had the opportunity to ask questions about my, or my child's, anticipated anesthesia and am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure. The anesthesiologist assumes no liability from the surgery/dental treatment performed while under anesthesia and that the dentist assumes no liability from the anesthesia performed.

I hereby give my consent for the use of anesthesia as explained above.

_____ _____
Signature of Patient's Legal Representative Date

_____ _____
Print Name of Person Signing Above Relationship to patient

I attest that I have discussed the risks, benefits, consequences, and alternatives of anesthesia with the above named patient or patient's representative and they have had the opportunity to ask questions, and I believe they understand what has been explained and consents or refuses treatment as noted above.

_____ _____
Signature of Attending Dentist Anesthesiologist: David Westerhaus DDS Date

_____ _____
Witness Date

Financial Agreement: Anesthesia for Dentistry
(Pediatric: 12 years old and younger)

Patient Name: _____ Service Location / Dental Office: _____

Name of person financially responsible: (print) _____ Relationship: _____

Email: _____ Contact Phone #: (_____) _____-_____ Appointment Date: _____

Fee Schedule: First Hour of Anesthesia: $600.00 Every additional 15 minutes: $150.00

Preoperative Time (15 min) + Surgery Time (To Be Determined) + Recovery Time (15 min) = Total Anesthesia Time

Surgery Time	**Total Anesthesia Time** (Minimum Time: 1 hour 30 minutes)	**Anesthesia Fee** (Minimum Fee: $900.00)
1 hour 15 minutes	1 hour 45 minutes	$1050.00
1 hour 30 minutes	2 hours	$1200.00
1 hour 45 minutes	2 hours 15 minutes	$1350.00
2 hours	2 hours 30 minutes	$1500.00
2 hours 15 minutes	2 hours 45 minutes	$1650.00
2 hours 30 minutes	3 hours	$1800.00
2 hours 45 minutes or more	(Each additional 15 minutes hereafter adds $150.00)	TBD

Estimated Fee Calculation:

Estimated Surgery Time _____ + 30 minutes = Estimated Total Anesthesia Time (See Estimated Anesthesia Fee Above) $_____

Subtract $600 Deposit due today for First Hour of Anesthesia: - $600.00

Estimated Balance Due on Day of Appointment: $_____

I, the undersigned, acknowledge full financial responsibility for the payment of anesthesia services provided by Dr. David Westerhaus. I understand that by signing this document, I am agreeing to pay the full fee for anesthesia services at the time services are rendered. I understand that the estimated total anesthesia fee quoted above is **only an estimate**. The balance due on the day on the appointment will be adjusted up or down according to the actual total anesthesia time. Anesthesia time begins when the patient is seated and ends when recovered and discharged to a responsible adult.

Due to the extensive time, effort and coordination between the dentist and anesthesiologist necessary in scheduling an appointment, a non-refundable deposit of $600 is required before the anesthesia appointment is confirmed. This is to make certain the patient complies with the instructions given prior to the anesthesia appointment, and to reserve the time of the dentist and the anesthesiologist. If anesthesia services cannot be performed or administered as planned because the patient does not appear at the agreed time or failure to follow the preoperative instructions, this deposit is forfeit. Forms must be received at least 2 weeks prior to the treatment date. The deposit will be transferred to anesthesia for a future date for illness requiring medical intervention.

It is important that reimbursement for the anesthesia fee by dental and/or medical insurance not be assumed. In general, insurance does not pay for anesthesia services. Please contact your insurance carrier to determine whether coverage is provided for your appointment. Upon request, an anesthesia statement of services will be provided to submit to your insurance carrier.

Payment Information:

We accept Cash, MasterCard, Visa, American Express and Discover. (Please circle one)

Name of person financially responsible: (print) _____Relationship:_____

Cardholder Name: (print) _____ Billing Zip Code: _____ Exp Date: _____

Credit Card Number: _____ Security Code on back of card: _____

By signing this form I am authorizing Dr David Westerhaus to charge my credit card. Should my credit card be rejected or denied by the credit card company for any reason, I understand that I must pay Dr David Westerhaus the amounts owed and hereby agree to make full payment. I agree to the remittance of deposit and anesthesia fees, cancellation policies and rescheduling policies. I have read, understand and agree to the estimate of fees, terms and conditions.

Signature: _____ Date: _____