Martin R. Boorin, DMD, PC

Anesthesia For Dental Health

SEDATION and ANESTHESIA for CHILDREN'S DENTAL CARE

This form will assist you in considering the benefits of sedation and anesthesia for your child if:

- Dental treatment has been postponed due to the need for multiple dental treatment sessions,
- You been delaying dental care for your child because you or they fear a painful experience,
- They have had previously unpleasant experiences during dental treatment,
- You would like to complete your child's dental treatment ……

Without pain … With little memory of the experience … Rapidly, using fewer visits

All parents want their children to receive the best comprehensive dental treatment possible. While many adults avoid dental treatment at some time in their life because of fear and anxiety, children react to dental treatment based on a limited understanding of its value and necessity. In many cases the pediatric dentist, hygienist and dental staff can present dental treatment to your child in a fun or interesting way that enables the completion of needed dental care.

Younger children typically experience a degree of stranger anxiety, a short attention span, and a limited tolerance for keeping their mouth open. Occasionally even a skilled pediatric dentist may have limited success completing dental treatment in fearful children. The complexity and magnitude of the dental treatment may reduce the success of behavior management strategies use by the dental team. Subsequent delays in receiving proper dental care can lead to oral pain, infections and loss of teeth.

In these circumstances, anesthesia services are available for your child's dental treatment. A qualified anesthesiologist who uses medications and monitors equal to those currently used in hospitals can provide this care. Children are often given a sedative prior to receiving their primary inhalation or intravenous anesthetic. Each child receives an individually prepared and titrated anesthetic with close and continuous monitoring of heart rate, blood pressure, respiration, and patient awareness. They remain in a sleep state with profound amnesia and pain control throughout their dental treatment. This enables the treating dentist to efficiently complete all planned dental or surgical treatment.

Anesthesia for children can make dental treatment a comfortable experience.

- It allows parents to choose treatment recommended by their children's dentists thus avoiding sub- optimal choices due to a child's fear or unanticipated, painful emergencies.
- Children do not remember the dental or surgical treatment and awaken with their parents present
- The stress of treatment for patients who gag easily during dental treatment can be eliminated.
- Root canal therapy, tooth removal, and surgical procedures all become well-tolerated, painless procedures.
- Children with mental and/or physical disabilities can receive treatment in a fully monitored, stress-free environment while they sleep. They are often discharged after a brief recovery period.

ANESTHESIOLOGY STAFF

Martin R. Boorin, DMD is an experienced, residency-trained, fully qualified dentist anesthesiologist. He is a graduate of the University of Connecticut, School of Dental Medicine and completed his two-year anesthesiology residency at Long Island Jewish Medical Center. Dr. Boorin is a diplomate of the American Dental Board of Anesthesia, and the National Dental Board of Anesthesiology. He has been a staff dentist anesthesiologist at Long Island Jewish Medical Center since completing his residency in 1987. He is the section chief for dental anesthesiology in the Department of Dental Medicine at Long Island Jewish Medical Center where he coordinates and provides dental resident education in anesthesia. Dr. Boorin is currently a clinical assistant professor, in the Department of Hospital Dentistry and Dental Anesthesiology, Stony Brook School of Dental Medicine. He is active in and lectured before numerous professional organizations.

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The Pre-anesthetic instructions herein must be strictly adhered to before undergoing anesthesia and will make the scheduled dental treatment under anesthesia safe and successful.

Neglecting any of the following instructions may compel the doctor to postpone the treatment
The Anesthesia Deposit will be forfeit if children eat on the day of treatment unless instructed to do so

PRE-ANESTHETIC INSTRUCTIONS

EATING AND DRINKING

Nothing to eat after midnight prior to your child's scheduled appointment unless otherwise instructed. Your Child is allowed moderate amounts of clear liquids (8 ounces) up to two (2) hours prior to the scheduled appointment. **CLEAR LIQUID = Water, Apple juice, Jello, Gatorade, Popsicles**
DO NOT GIVE: Milk, Soup, Non-clear or Pulp-containing juice

MEDICATIONS

Prescription medications should be taken as per their regular schedule, unless previously discussed and modified by Dr. Boorin. **MEDICATIONS MUST ONLY BE TAKEN WITH A CLEAR LIQUID.**
Vitamins, herbal products, and non-prescription medications **should not** be taken.

CHANGES IN HEALTH

A change in your child's health, especially the development of a cold or fever, is very important. Inform our office of any change in their health that occurs prior to your child's appointment. For their safety, we may need to reschedule for another day.

HOME PREPARATION

Make sure to give your child a good night's sleep before the day of the procedure. They should wear comfortable, loose fitting clothing. We suggest a short sleeve shirt, and a sweat shirt over it if needed. Contact lenses must be removed. A blanket and a change of clothing are suggested in case of accident.

ARRIVING

Arrive early enough to allow for a discussion of your child's health, a brief examination, consent for anesthesia and question answering.

GETTING HOME

Children will be sleepy after the procedure and must be accompanied by at least one parent if not two adults, one to drive and the other to attend to the child during the ride home. They must be seat belted in as they are less prepared to brace themselves during sudden stops. Do not take mass transportation (bus, train). Children may develop nausea on the ride home, be prepared.

HOME

A responsible adult should remain with the patient until the next day

POST-ANESTHETIC INSTRUCTIONS

ACTIVITY

After returning home, your child should rest for the remainder of the day and be observed. It is common for patients to be sleepy, dizzy or off-balance after receiving anesthetics. Children may return to school the next day if they have had an early to mid-day procedure and an uneventful night.

EATING AND DRINKING

Upon arrival home, the first drink should be one ounce of water or clear fruit juice every 15 minutes for 1.5 hours, followed by clear liquids and soft carbohydrate foods for an additional 1.5 hours. Give your child small drinks frequently, throughout the day. Hydration is more important than foods. Hold dairy and meats for at least 3 hours following your arrival home.

POST TREATMENT EFFECTS

Some common after-effects include sleepiness, dizziness, nausea, (may be worse after car ride home), soreness of mouth, jaws and throat, dry mouth, muscle aches and shivering. These symptoms may last for 1 to 3 hours, and on rare occasions somewhat longer. Children receiving treatment in the afternoon may be more sleepy afterward due to coinciding nap times.

INTRAVENOUS SITE

A very small percentage of patients experience post-operative tenderness and/or redness in their hand or arm which may be a chemical phlebitis associated with intravenous infusion. If this occurs please contact Dr. Boorin at (516) 776-0716 immediately. If phlebitis does occur the patient should receive an anti-inflammatory agent (acetaminophen or ibuprofen). Apply warm compresses, and elevate the arm.

SEEK ADVICE IF

Vomiting persists beyond four hours on four separate occasions. Unable to drink liquids 4 hours after arrival at home. Temperature elevates rapidly or remains elevated. Other matters cause concern.

PAIN MEDICATION

Expect to give your child Tylenol or Ibuprofen after the procedure to minimize any throat, mouth or tooth soreness. This should be started on arrival at home and repeated every 4 (Tylenol) or 6 (Ibuprofen) hour interval until the next day to ensure a good nights rest.

I have read, understand and agree to follow the above instructions **Date:** ______________

Name: ______________________________ **Signed:** ______________________________

Financial Agreement & Insurance Information

Martin R. Boorin, DMD, PC

Everyone benefits when financial arrangements are agreed upon in advance. This material will acquaint you with our financial policies regarding payment of anesthesia services and submission of insurance claims.

Patient's Name: ______________________________ **Date of Procedure** ____/____/____

Dentist / Surgeon's Name: ______________________________

Anesthesia Fee Estimation:

Dentist's ESTIMATED dental treatment time	______ Min
Estimated anesthesia time [dental treatment time **plus preop / postop time (additional 45 minutes)**	______ Min
Initial 60 Minutes	$ 1125.00
Additional Time ($ 125 x ______)	$ ______
Total Estimated Anesthesia Fee	$ ______
Less the Deposit	$ 500.00
ESTIMATED TOTAL DUE ON THE DAY OF SURGERY	$

Anesthesia fees are based on units of time:
$ 1125 for the first 60 minutes of anesthesia
$ 125 for each additional 15-minute increment of anesthesia
(The anticipated Minimum Charge for anesthesia is $ 1125)

PAYMENT FOR ANESTHESIA SERVICES IS DUE IN FULL ON THE DAY SERVICES ARE PROVIDED:
I, *the Parent/Guardian*, acknowledge full financial responsibility for the payment of anesthesia services. I understand that by signing this document, I am agreeing to pay Dr. Martin R. Boorin his full fee for anesthesia services on the day of services rendered. If the anesthesia time exceeds the estimate, the patient/parent/guardian will be responsible for the additional fee. If the anesthesia fee is less than the estimated time, the patient/parent/guardian with be charged based on the actual anesthesia time. I understand that payment for anesthesia services may be made by: Cash, Bank Check / Money Order, or Credit Card (Visa / MC / Discover).

DEPOSIT POLICY:
It takes great effort, time, and coordination between the offices of the dentist and dentist anesthesiologist to schedule your appointment. **A Deposit of $ 500.00 is therefore required at the time the treatment visit is scheduled. Your $500.00 deposit is NON-REFUNDABLE with the exception of the onset of illness or cancellation greater than 7 days in advance of the scheduled treatment date**. Failure to comply with instructions relating to eating and drinking, or a minimum 7 day advanced cancellation notice will result in cancellation of the appointment and forfeiture of your deposit. This financial agreement, along with the deposit, must be signed and returned to the address below or the treating dentist's office prior to the anesthesia appointment. Deposits may be received by one of the following methods; Cash, Bank Check, Money order, or Credit Card (please complete form below).

INSURANCE: **As a Courtesy, We Will Submit to Your Medical Insurance Carrier on Your Behalf and Require Completion of an Insurance Data Form and Your Medical Insurance Card**

It is important that reimbursement for the anesthesia fee by dental or medical insurance programs NOT be assumed. Many insurance policies DO NOT pay for anesthesia services for dentistry or have limitations on individual policies. We are an out of network provider. You must contact and check with your Dental or Medical Insurance Company representatives to discuss your specific benefits. You will receive a detailed "Anesthesia Statement of Services Form" at the conclusion of the anesthesia procedure. An insurance company is more likely to accept a claim when the patient has a documented need for anesthesia services. These may include, but are not limited to the following: ***history of failed local anesthesia, allergies to local anesthetics, cerebral palsy and heart/lung diseases***. A note from your physician acknowledging the need for anesthesia services will be helpful.

I have read, agree, and received a copy of the financial agreement and deposit policy.

Signature: ______________________ **Print Name:** ______________________ **Date:** __________

Credit Card (circle): MC Visa Discover **Card # :** ______________________ **Exp. Date:** __________

Deposit Amount: $ ________ **Security Code [Back of Card, 3 digits for MC, Visa, 4 digits for AE]** ____________ **[Required]**
The Cardholder acknowledges responsibility for payment of the non-refundable deposit and agrees to perform the obligations set forth in the cardholder's agreement with the issuer.

Cardholder Signature: ______________________ **Cardholder Name:** ______________________ **Date:** __________

Cardholder Address: ______________________ **City:** ______________ **State:** ________ **Zip:** ________

Office use: Deposit Payment: **Cash** **Check / Money Order [# _____]** **Credit Card**
Amount of Deposit Received: $ ________ Received by: ______________ **Date:** ________

P.O. Box 107 Huntington Station, NY 11746 Office: (631) 940-3690 Fax: (631) 239-8405

Martin R. Boorin, DMD, PC

CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your child's/dependent's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your child's/dependent's protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We will provide you a copy to read prior to signing this Consent at your request. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's/dependent's protected health information that we maintain.

Right to Revoke:

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed in the Notice of Privacy Practices. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat or continue to treat your child/dependent if you revoke this Consent.

☐ **Consent Given**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure my child's/dependent's protected health information to carry out treatment, payment activities and health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters/information pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters/information. I further understand that I may revoke this Consent in the future if I should so desire.

I further understand that I have the right to review the Notice of Privacy Practices of Martin R. Boorin, DMD, PC and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

☐ **Revocation of Consent**

I hereby revoke my Consent for your use and disclosure of my or my child's/dependent's protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took, in reliance on my Consent before you received this Notice of Revocation. I also understand that you may decline to treat or to continue to treat my child/dependent after I have revoked my Consent

______________________	______________________	__________
Print Name	Signature	Date

Patient's Name ______________________