ADULT OUTPATIENT DENTAL PROCEDURE PACKET

REQUIREMENTS:

Patient Information
Informed Consents
Patient Bill of Rights and Privacy Practices
Policies and Authorizations
Medical Clearance Form

STEPS TO COMPLETE:

Review all documents with the responsible party (e.g. POA, guardian, patient).
Ensure **all** forms are **signed** and **dated**.
Return completed packets via email or fax **2 weeks** before procedure.

PRE-OPERATIVE INSTRUCTIONS:

Eating and Drinking:
- Do **NOT** eat or drink anything after **MIDNIGHT** the night before your procedure.

Medications:
- Do **NOT** take prescribed medications, unless your anesthesiologist indicates.
- If approved, medications may be taken with a **small sip** of **water** only.
- **DISCONTINUE ALL BLOOD THINNING MEDICATIONS 5 DAYS PRIOR TO PROCEDURE.**

Health Changes:
- Tell our office if you develop a cold, fever, illnes or other health changes.
- Your procedure may be rescheduled if you are not in good health.

Transportation and Support:
- A responsible party must be available to provide transportation after procedure.
- Patient should be checked regularly for 24 hours following procedure.

IF YOU HAVE QUESTIONS, CONTACT:

Katie Evans, BSN
Phone: 801-455-2756
Email: katie@caresurgical.org
Fax: 855-224-0040
Care Surgical Main Line: 801-833-0515
Address: 151 E 5600 S Suite 104 Murray, UT 84107

PATIENT INFORMATION

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Birth Date: ______________________ Gender: ☐ Male ☐ Female ☐ Other

Address: ____

City: ______________ State: ______________ ZIP ________

Email: ______________________ Phone Number: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: ______________________ Phone: ______________________

INSURANCE INFORMATION

Name of Insurance Company: ______________________ State: ______________

Member ID: ______________________ Group: ______________________

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other ________

MEDICAL HISTORY

Is the patient currently under the care of a doctor? ☐ Yes ☐ No

Doctor's Name: ______________________ Doctor's Phone Number: ______________

Is the patient taking any medications? ☐ Yes ☐ No Is the patient taking a GLP-1? ☐ Yes ☐ No

Please list medications (or attach list): ____

Has the patient ever been hospitalized? ☐ Yes ☐ No

Has the patient had surgery in the past? ☐ Yes ☐ No

Does the patient have problems with bleeding or bruising? ☐ Yes ☐ No

Does the patient have any allergies (medicine, food, latex)? ☐ Yes ☐ No

Please list allergies: ____

What is the patient's current weight? ____

Is the patient wheelchair dependent? ☐ Yes ☐ No

Is the patient oxygen dependent? ☐ Yes ☐ No How many liters? ______________

Please circle any of the following medical conditions that we should be aware of:

Heart Disease	Kidney disease	Seizures	Cerebral Palsy	Cancer
Asthma	Liver disease	Memory loss	Thyroid disease	ADD/ADHD
Diabetes	Stroke	Autism	Anemia	Other: ________

Current vaccination status: ☐ Up to date ☐ Not up to date ☐ Unknown

______________________ ______________________ ______________________

Signature of Patient or Responsible Party Relationship to Patient Date

All information on this page is correct to the best of my knowledge

INFORMED CONSENTS

DENTAL TREATMENT CONSENT

I understand that the patient may receive one or more of the following dental treatments at Family Surgical Suite:

- Dental Exam
- X-rays
- Crowns
- Fillings
- Extractions
- Pulpotomy (treatment of tooth nerve)

DENTAL TREATMENT RISKS

I understand that all dental and oral surgery procedures have risks. These may include:

- Pain, swelling, bruising
- Bleeding or infection
- Injury to lips, mouth or tongue
- Temporary or permanent numbness
- Dry socket after tooth removal
- Sinus involvement for upper teeth

GENERAL ANESTHESIA CONSENT

I understand that the anesthesia provider will choose the safest option based on the patient's health and needs. I understand that dental treatment will be done using medicine to reduce pain, anxiety, and awareness. This may include:

- Sedatives
- IV sedation
- Anesthesia gases

GENERAL ANESTHESIA RISKS

I understand that sedation or anesthesia also has risks, including:

- Allergic reactions
- Nausea and vomiting
- Headaches and fatigue
- Heart or blood pressure issues
- IV site irritation or infection
- Breathing or airway problems
- Rare but serious events such as malignant hyperthermia, stroke, brain injury, heart attack, coma, or death

UNEXPECTED FINDINGS AND EMERGENCY CARE

I understand that unexpected problems may be found during treatment. I give permission for the dental team to perform additional treatment needed for safety and health. If an emergency occurs, I give permission for the medical team to provide necessary lifesaving care, including CPR and airway or heart support.

CONSENT AND SIGNATURE

I voluntarily give permission for the dental treatment and anesthesia described above.

____

Printed Name of Patient

________________________________ ________________

Signature of Patient or Responsible Party & Relationship to Patient   Date

________________________________ ________________

Signature of Dentist   Date

PATIENT BILL OF RIGHTS AND PRIVACY PRACTICES

PATIENT BILL OF RIGHTS

As a patient of Family Surgical Suite, you have the right to:

- Be treated with respect, dignity, and consideration; and receive care in a safe environment.
- Receive clear, understandable information about your diagnosis, treatment options, and outcomes.
- Ask questions and receive answers about your care; and participate in decisions about your care.
- Refuse treatment, to the extent permitted by law.
- Expect privacy and confidentiality of your medical information.
- Expect access to emergency health care services when and where the need arises.
- Request corrections to your medical records if you believe information is incorrent or incomplete.
- Receive information about fees, billing, and insurance coverage (including Medicare and Medicaid)

PRIVACY PRACTICES

Family Surgical Suite is committed to protecting your health information. This summary explains how your information may be used and your rights regarding that information.

We may use or share your health information (called Protected Health Information or PHI) to:

- Provide or coordinate your care.
- Bill for services and process insurance, including Medicare or Medicaid.
- Operate our practice and improve quality and safety.

Other situations where information may be shared:

- Public health and safety purposes, as well as legal or law enforcement requirements.
- Reporting suspected abuse or neglect.
- Emergency situations when consent cannot be obtained.

You have the right to:

- Request confidential communication regarding PHI.
- Review and request copies of your medical records and request corrections to your medical records.
- Receive a full copy of our Notice of Privacy Practices at any time.

QUESTIONS OR CONCERNS

If you have questions about the Patient Bill of Rights or Privacy Practices, please contact:

- Family Surigcal Suite Administration: 801-495-1064
- Utah State Health Department: 1-800-662-4157
- Utah State Ombudsman: 801-538-4589

POLICIES AND AUTHORIZATIONS

First Name: ______________________ Last Name: ______________________

Birth Date: ______________________ Gender: ☐ Male ☐ Female ☐ Other

POLICIES

- I have received, read, and understand my rights as a patient as outlined in the Patient Bill of Rights.
- I understand that Family Surgical Suite does not accept advance directives.
- I understand that no smoking or tobacco use (including vaping or chewing tobacco) is allowed inside or outside the building from check-in until discharge.

AUTHORIZATIONS

- I give permission for doctors, nurses, and staff to give medications and provide necessary care.
- I understand how my medical information may be shared with my insurance company and other healthcare providers involved in my care.
- I understand that I am responsible for the payment of my care. Insurance is billed as a courtesy to me. If insurance does not pay the balance in full, I will be billed for the difference.
- I understand that payment is due within 30 days and that unpaid balances may result in additional charges, as allowed by law.

______________________ ______________________

Signature of Patient or Responsible Party & Relationship to Patient   Date

**Terms: Net 30 days from the date of invoice, unless otherwise indicated. A finance charge of 1.5% per month (annual rate 18%) of the unpaid balance and our billing fee will be added monthly. Should collections become necessary, the responsible party agrees to pay an additional 40% for collection agency fees and all legal fees of collection, without suit, including attorney fees, court costs and filing fees. If collections become necessary, all courtesy discounts will be added back to the balance.*

MEDICAL CLEARANCE FORM

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Birth Date: ______________________ Gender: ☐ Male ☐ Female ☐ Other

Facility / Care Center (if applicable): ______________________

Primary Care Provider: ______________________

Phone: ______________________ Fax: ______________________

PROPOSED DENTAL TREATMENT

Dental Provider: ______________________

- Dental cleaning
- Fillings and crowns
- Extractions
- Local anesthesia
- IV sedation and monitored anesthesia care
- General anesthesia

MEDICATION RECOMMENDATIONS

Is the patient currently taking anticoagulant or antiplatelet medication? ☐ Yes ☐ No

If YES, please list the date of the last dose: ______________________

If YES, please list medication(s) and most recent INR (if applicable): ______________________

Is antibiotic prophylaxis recommended for this patient? ☐ Yes ☐ No

If YES, please specify medication and instructions: ______________________

MEDICAL CLEARANCE FOR DENTAL TREATMENT UNDER ANESTHESIA

Based on a medical evaulation, please indicate the patient’s current status:

☐ **Medically cleared** to undergo the planned dental treatment under anesthesia

☐ **Medically cleared** for anesthesia with the following precautions: ______________________

☐ **Not medically cleared** for anesthesia at this time. ______________________

This clearance reflects the patient’s current medical status and does not replace the anesthesia provider’s independent evaluation on the day of the procedure

______________________ ______________________

Signature of Provider Date