West Michigan Pediatric Dentistry
845 East 16th St
Holland, Michigan 49423
Daniel L. Bolt, D.D.S. Thomas J. Bouwens, D.D.S. Morgan Hess D.D.S Harold Robinson D.M.D.
Phone: 616-392-2381 Fax: 616-392-3748

Consent for Dental Treatment under General Anesthesia in a Hospital or Office setting

- ✓ The following services are expected to be provided:
  - Restorations/Extractions/Fluoride/Prophy/X-rays
- ✓ I understand that it may be necessary to alter the treatment plan during the surgery and I give permission to provide alternative and/or additional procedures as deemed necessary by the dentist in charge.
- ✓ The nature of the dental treatment, the risks and the alternatives have been explained to me. Also, the risk and alternative of refusing dental treatment has been explained.
- ✓ All patients undergoing general anesthesia are subject to risk of medical complications including, but not limited to: sore throat, nausea and vomiting, respiratory and cardiovascular problems, malignant hyperthermia and death.
- ✓ If medical treatment becomes necessary, it will be provided by your child's physician or a member of the hospital staff. The parent or guardian is financially responsible for this treatment.
- ✓ I understand and have had ample opportunity to discuss all of the above information. My questions have been answered.
- ✓ I understand and agree that I am financially responsible for any charges for dental treatment that are not covered under my dental insurance.

I REQUEST TREATMENT FOR MY CHILD

I am the patient's: ____mother ____ father ___ legal guardian ____other

_____ _____ _____

Parent/Legal Guardian signature Patient's Name Today's date

Explained by: _____ _____
date

Dentist: _____ _____
date

Confidential Fax Message

Date _____

Facility _____ Fax _____

RE: **PATIENT NAME** _____ DOB _____

URGENT: The above-named patient is having dental work completed under general anesthesia. Please fax the medical records to:

☐ Fax 616-377-5507

Delia Lambert
Surgical Coordinator
West Michigan Pediatric Dentistry
845 E. 16th Street
Holland, MI 49423
Phone: 616-928-9870

☐ Fax 616-392-3748

Nicole Letts
Surgical Coordinator
West Michigan Pediatric Dentistry
845 E. 16th Street
Holland, MI 49423
Phone: 616-392-2381

☐ Please send pre-op notes.

☐ Please send most recent well child visit notes.

☐ Other _____

Thank you for your immediate response to this matter.

CONSENT TO RELEASE MEDICAL RECORDS

To whom it may concern:

I, the undersigned, do hereby authorize the release of any medical records to West Michigan Pediatric Dentistry on behalf of the above-named patient, who is a minor.

Legal Guardian Signature _____ **Date** _____

CarePoint
ANESTHESIA GROUP

1179 E Paris Ave SE, Suite 130
Grand Rapids, MI 49546-3682
Phone: (616) 226-1370 : Fax: (616) 327-6370
Email: michigan@carepointanesthesia.com
https://cpmich.com

NEW PATIENT INTAKE FORM
(with Healthy Kids Dental Program)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: M [ ] F [ ] Weight (lbs.): _____ Height: _____

Healthy Kids of Michigan: **BCBS ID#**_____ **Delta Dental ID#**_____

Dental Office Name: West Michigan Pediatric Dentistry Contact Number: 616-928-9870

Dental Office Address: 845 East 16th Street, Holland, MI 49423

Primary Physician Name: _____ Contact Number: _____

(If applicable) Specialist Physician Name: _____ Contact Number: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Full Name: _____ Contact Number: _____

Please check one.
Mother [ ] Father [ ] Legal Guardian [ ] Other: _____ Date of Birth: _____

Mailing Address: _____

Email Address: _____

PREGNANCY/NEONATAL HISTORY

1. Were there any complications during pregnancy or delivery? [ ] NO [ ] YES, reason(s): _____
   _____
2. Delivery: [ ] VAGINAL [ ] C-SECTION, reason(s): _____
3. Was your child premature? [ ] NO [ ] YES, born at number of weeks _____
4. Were there any complications during the newborn period? _____
   _____
   _____
   _____

INFANCY/CHILDHOOD/ADOLESCENCE HISTORY

1. Does your child have any allergies to drugs, supplements, or latex? [ ] NO [ ] YES, please select type of reaction(s): [ ] Rash [ ] Hives [ ] Emergency Room [ ] Other: _____
2. Has your child ever been hospitalized? [ ] NO [ ] YES, reason? _____

3. Has your child ever had surgery? [ ] NO [ ] YES, reason? _____

4. Has your child ever had general anesthesia? [ ] NO [ ] YES If so, any problems with anesthesia?

_____

5. Has anyone in your family had problems with general anesthesia? [ ] NO [ ] YES If so, what problems?

_____

6. Has your child ever been treated for or diagnosed with any of the following conditions?

	YES	NO	WHEN	MEDICINE / TREATMENT
Heart Diseases				
* Heart Murmur				
* High Blood Pressure				
* Irregular Heart Beat				
* Congenital Heart Defect				
* Other Heart Problems				
Lung Diseases:				
* Wheezing / Bronchiolitis				
* Asthma				
* Pneumonia				
* Obstructive Sleep Apnea				
* Other Lung Problems				
Other Medical Conditions:				
* Diabetes				
* Kidney Disease				
* Seasonal Allergies / Eczema				
* GERD / Ulcer / Hernia				
* Recurrent Ear Infection				
* Seizure Disorder				
* Psychiatric Condition				
* Genetic Syndrome				
* Learning Disability				
* Anemia				

Please list any other medical conditions: _____

_____

_____

_____

CarePoint
ANESTHESIA GROUP

1179 E Paris Ave SE, Suite 130
Grand Rapids, MI 49546-3682
Phone: (616) 226-1370 : Fax: (616) 327-6370

FINANCE POLICY AGREEMENT

For (Child's Name): _____ ***Scheduled Appointment:*** _____

The **CarePoint Dental Anesthesia Group of Michigan**, herein after known as "CarePoint", is dedicated to providing specialized anesthesia services to the familiar and comfortable environment of your dentist's office, bringing a tailored and personal touch to your child's care. We would like to advise you of your financial obligations. Please **initial** below that you have read, understood, and acknowledge this Finance Policy Agreement.

____ CarePoint is a completely separate entity from your dentist and that all related fees, operative times and/or dental procedures are billed separately. CarePoint is a "Fee-for-Service" company and payment is due **2-business days** prior to the scheduled appointment.

____ For **Pediatric patients** (20 years and younger), we require a minimum payment of **$1,050** (90-minutes or less of dental anesthesia). The **$1,050** payment is due **2-business days prior** to your child's scheduled appointment. Should the dental procedure exceed the allocated 90-minutes, an additional **$175 per 15-minute increments** will be accessed. The remaining balance will be charged to the card on file unless other special arrangement(s) have been made. We do accept all major credit cards, debit cards, Health Savings Account (HSA), flex spending cards, CareCredit (6-months term), cash, money orders, or checks for our services. Payment(s) can be made through our website at https://cpmich.com.

____ We require a minimum of **2-business days** notification to cancel your child's appointment. A "**broken appointment**" fee of **$300** fee will be accessed should you cancel less than the required 2-business days notification. A "no call" or a "no show" status will be considered a "broken appointment" and the $300 fee will apply. This fee will be deducted from payment received by CarePoint.

____ We reserve the right to charge a **$25 processing fee** for any requested refunds. This fee will be deducted from payment received by CarePoint. The refund payment will be in the form of a bank issued check by JPMorgan Chase Bank.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read, understood, and acknowledge that I have retained a copy of this Finance Policy Agreement. I also understand and acknowledge my financial responsibility for the dental anesthesia services provided by CarePoint Dental Anesthesia Group of Michigan. By signing below, I authorize CarePoint to submit payment for any remaining balance due on or after the date of service. I can alternately provide my card information through CarePoint's website in the form of a payment.

Parent/Legal Guardian Signature: _____ Date: _____

Credit Card Payment Authorization

Please check: [ ] **VISA** [ ] **MC** [ ] **AMEX** [ ] **DISCOVER** [ ] **CARE CREDIT** (6-Months Term)

Cardholder Name: _____

Card Number: _____ Expiration Date: _____ CVV: _____

Cardholder Signature: _____ Billing Zip Code: _____

*** PRE-OPERATIVE GUIDELINES ***

- Nothing to eat after midnight (this includes gum, candy, or anything other than clear liquids)
- Clear liquids (i.e., water, apple juice, Gatorade, 7-Up, or Sprite) can be consumed after midnight, but they must be stopped four (4) hours before the appointment time that was provided to you by the dental office.

*** IMPORTANT NOTIFICATION ***

A Parent or a Legal Guardian must be present and remain at the dental office during the time of service.

HIPAA AND OUR PRIVACY POLICIES

(The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") addresses the manner in which a Patient's individual health information may be used or disclosed by Covered Entities (as defined in HIPAA) and other individuals and entities, such as a Provider. For more information regarding your rights under HIPAA, please visit their site at https://hhs.gov/ocr/privacy.)

Please initial below that you have read, understood, and acknowledge the following:

— I give CarePoint permission to communicate with me via email, text messaging, and to my cellular devices.

— I understand that I have the option of accessing and/or viewing the Notice of Privacy Practices online at https://cpmich.com or have a printed copy provided to me.

— If needed, I hereby request and give my authorization to my child's medical providers to release his/her medical history records to CarePoint. I also understand that I can revoke this permission at any time.

— I understand that I am giving my permission to CarePoint the use and disclosure of my child's protected health information in order to carry out the dental anesthesia treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke this permission at any time.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read the above pre-operative guidelines and that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my child's treatment and treatment results.

Parent/Legal Guardian Signature: _____ Date: _____

CarePoint
ANESTHESIA GROUP

1179 E Paris Ave SE, Suite 130
Grand Rapids, MI 49546-3682
Phone: (616) 226-1370 : Fax: (616) 327-6370
Email: michigan@carepointanesthesia.com
https://cpmich.com

CONSENT FOR DENTAL ANESTHESIA SERVICES

The following is provided to inform patients about having treatment under dental anesthesia. The information is not presented to make you more apprehensive, but rather to enable you to better understand the risks and benefits involved with anesthetic treatments.

For (Child's Name): _____ ***Scheduled Appointment:*** _____

I, the undersigned, hereby authorize and request any doctor represented with CarePoint Dental Anesthesia to administer anesthesia to my child as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for my child's well-being may be performed to supplement the planned anesthesia. It has been explained to me that all types of anesthesia, although safe, involve some risks and no guarantees can be made concerning results. Serious complications are very rare. The following are complications that may be associated with the anesthetic treatment:

Common Complications:

- Pain and/or bruising at the IV site
- Sore throat and/or hoarseness
- Muscle aches
- Nausea and/or vomiting

Rare Complications:

- Heart injury
- Brain damage or death

Uncommon Complications:

- Headaches
- Injuries to lips, teeth, mouth or throat from airway instruments or devices
- Unexpected drug reaction
- Infection at intravenous site and veins nearby
- Bleeding/injury in the nose due to passage of a breathing tube
- Lung infection
- Eye injury or infection
- Weakness in breathing after awakening
- Nerve Damage

- Alternative options to deep sedation/general anesthesia have been discussed with me and may include the use of local anesthesia with nitrous oxide sedation or local anesthesia alone.
- I confirm that my child (the patient) has not had anything to eat or drink after midnight (this includes gum, candy, or anything other than clear liquids). Clear liquids (i.e., water, apple juice, Gatorade, 7-Up, or Sprite) can be consumed after midnight, but they must be stopped four (4) hours before the appointment time that was provided to you by the dental office.
- I certify that to my knowledge that my child (the patient) is not pregnant or trying to become pregnant.
- I have read and agree to the HIPAA Notice of Privacy Practices posted on our website www.cpmich.com.

ACKNOWLEDGEMENT

I, the undersigned, consent to the anesthesia deemed appropriate by my child's anesthesiologist. I acknowledge that I have read this form or had it read to me and that I understand the risks, alternatives, and expected results of the anesthetic plan of care.

Parent/Legal Guardian Signature: _____ Date: _____