DENTAL AND MAXILLOFACIAL ANAESTHETIC GROUP

Anaesthetic Consent & Authority

IV SEDATION OR GENERAL ANAESTHETIC

It is important that all the questions in this form are answered accurately to assist us in providing the best possible treatment for you and your safety.

YOUR NAME: _____ **AGE:** _____

YOUR WEIGHT: _____ **YOUR HEIGHT:** _____

FITNESS LEVEL _____

How far can you walk without stopping?

Around the house ☐

Around the block ☐

Half a flight of stairs ☐

One flight of stairs ☐

Two flights of stairs ☐

PREVIOUS OPERATIONS _____

Please list previous operations _____

_____

Were there any complications? NO ☐ YES ☐

Have you, or anyone in your family, ever had any complications with anaesthetics? NO ☐ YES ☐

Have you ever experienced Nausea or Vomiting? NO ☐ YES ☐

If Yes, please provide details: _____

_____

_____

DENTAL PROSTHETICS _____

Do you have dentures, crowns/bridges, or loose teeth? NO ☐ YES ☐

If yes, give details:

_____

GOING HOME _____

You must have a person to pick you up after any form of sedation. It's both a legal & medical requirement.

Name of person picking you up _____

Mobile No. _____ Work Tel. _____

Address where you are staying after surgery _____

I, (patient / parent / guardian) _____

Of (address) _____

1. CONSENT TO SURGICAL PROCEDURE & ANAESTHETIC

I consent to the following proposed procedures: _____

_____

To be carried out upon (self / patients name) _____

By (dentist/surgeon name) _____ _____

The full nature, risks, complications, and benefits have been clearly explained to my satisfaction.

I also consent to the administration of anaesthetic, medicine or any other forms of treatment that would be normally associated with this procedure. I understand that the treatment plan may need to vary due to circumstances at surgery. I agree to any such variations where it is deemed to be in my best interests. I also understand that although the procedure will be carried out with all due care and professionalism, in some cases the expected result may not be achieved. I have had the opportunity to ask questions about this procedure and am satisfied with the information I have received. Should any person sustain injury from any needle / instrument used during my procedure or admission to this surgery, I consent to a blood sample.

2. CONSENT TO COSTS

I understand that the cost for Sleep Dentistry is split into three categories:

- **Dental Treatment** – I understand that the balance of fees are payable on the day of surgery.
- **Anaesthetic Facilitation Fee – $250.00 per hour**. This is charged by the Facility after the surgery and is based on the length of the procedure and recovery time.
- **Anaesthetic Fees** – this will vary according to the length of time of the anaesthetic and the time that the anaesthetist attends to you during pre-op and recovery. It will be billed separately by the anaesthetist as outlined below and is also due on the day of treatment:

Procedure (One Only Applies)	**Anaesthetist Fee**	**MEDICARE & SAFETY NET REBATE (Min. - Max.) ^**	**Out of Pocket Expense (approx.)**
Sinus and Bone Grafting Only	$3,200	$1,470 - $1,740	$900 - $1,400
Full Arch Implants	$3,950	$2,030 - $2,300	$1,100 - $1,500
Full Arch Implants WITH Grafting	$4,950	$2,830 - $3,100	$1,200 - $1,600
Full Upper & Lower Implants	$5,950	$4,100 - $4,380	$1,300 - $1,700
All Other Procedures: $650 first Hour, then $325 per half hour increment		Medicare Rebate: One third of fees up to the Safety Net, and then 80% of the balance	

^ *The rebates shown are provided as a guide only and may vary from patient to patient depending on safety net entitlements. As of 1 July 2012, changes introduced by the Government in the new budget will further affect your rebate entitlements. Please check any new conditions with Medicare and what your safety net is so as to accurately estimate the out of pocket expenses.*

I understand that the charges for the anaesthetic and facility fees will be processed on the day of treatment and that I will receive an itemised anaesthetic Invoice and receipt.

3. DECLARATION

I understand that failure to make a full disclosure in my medical, dental and social history may place me (or the above named patient) at undue medical risk. I consent to services, procedures and payments noted above. I understand, acknowledge and accept that I am financially responsible for the services provided for my self or the above named patient, regardless of insurance coverage, Medicare benefits or tax refunds.

Signed	*Date*

4. ANAESTHETIC PAYMENT AUTHORISATION

I authorise for the appropriate reduction amount for the anaesthetic, facility fee, and the fees associated with any variations as deemed required by my surgeon, to be charged to my credit card **following my surgery.**

Payment Type (insert ☑) ☐ Visa ☐ MasterCard ☐ Cash/Cheque

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp ☐☐ / ☐☐

Security Code (three digit code on the back of your card) ☐☐☐

Signed	*Date*