

FAX

PATIENT PROFILE
ANESTHESIA PARTNERS OF NORTH TEXAS, LLP

FAX

Please fax this to our office at 817-421-7560 to confirm your appointment.

1) SEDATION/ANESTHESIA PLAN * Ketamine * IV Sedation * General Anesthesia

2) PROCEDURE PLAN DENTIST: _____

Length of procedure including time for x-rays, cleaning and impressions _____ : _____
Procedure: ___ X-rays ___ Restoration ___ Extractions ___ Dental Impressions
___ Root Canal ___ Implants ___ ABR Other _____

3) HEALTH HISTORY

Patient name (Last, First) _____ Date of Procedure ___ / ___ / ___
Age ___ yr Date of Birth: ___ / ___ / ___ Ht ___ Weight ___ lbs. ___ kg
Medications: _____ Allergies to medication? _____
Hospitalizations: _____ Allergies to food? _____
Surgeries: _____ Anesthesia problems? _____
Family history of anesthesia related problems? _____

Table with 4 columns: History of: (please circle), YES, NO, Comments and details. Rows include Snoring, Obstructive sleep apnea, Seasonal allergies, etc.

Please review the PATIENT INSTRUCTION sheet for nasal Afrin instructions.

4) METHOD OF PAYMENT

Name on credit card (Print) _____
*VISA * MASTERCARD *American Express # _____
Exp ___ / ___ / ___ Authorization _____
Payment \$ _____ Date: ___ / ___ / ___
Parent Signature: _____ Phone: _____

CARE CREDIT Number _____
Exp ___ / ___ / ___ Authorization _____
Payment \$ _____ Date: ___ / ___ / ___
Parent Signature: _____ Phone: _____
* I plan to pay with cash \$ _____ * I plan to pay with a check \$ _____

Patient/Parent/Guardian (Print) _____
Patient/Parent Phone: Daytime _____ Night _____
Email _____

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Please fax this to our office at 817-421-7560 to confirm your appointment.

You will be contacted by our office in order to secure payment; if you have any questions please contact our office @ 817-907-4031.