Medical Hx

Dental Office

Procedure Date
Select Date

Patient Last Name

Patient First Name

Patient DOB
Select Date

Gender
○Male○Female

Parent Name

Address

City

State

Zip

Primary Phone

Secondary Phone

Email address

I prefer to be contacted by:
○Text○Email○Phone

Anesthesia Fee Estimate Form

Patient Name:

Estimated Dental Procedure Minutes	Total Prepaid Fee	Deposit due at scheduling	Balance due prior to procedure
5	**$450**	$250	$200
20	**$650**	$250	$400
40	**$850**	$250	$600
60	**$1050**	$250	$800
80	**$1350**	$250	$1100
100	**$1550**	$250	$1300
120	**$1800**	$250	$1550
140	**$2100**	$250	$1850
160	**$2350**	$250	$2100
180	**$2600**	$250	$2350
200	**$2900**	$250	$2650
220	**$3200**	$250	$2950
240	**$3500**	$250	$3250

Estimated anesthesia minutes given by dentist: minutes

Payment Policy:

- $250 Deposit is due at the time of scheduling. There is a $250 charge for patients who fail to keep the IV Sedation appointment without giving a 24 hour notice.
- Our financial office can help patients with medical insurance determine their out of network benefits. On the date of service you will be given a Superbill to file the anesthesia through your out of network benefits. Many medical insurance companies do not cover anesthesia services for office based dental care, however, PDAA is commuted to fully assisting you with the pursuit of any potential reimbursement.
- Your dental treatment plan may change after treatment is begun. Charges for anesthesia services may be more or less than the estimated amount based on the final length of the procedure. The anesthesia charges may be more than initially estimated and **an additional payment by credit card is due at the time of service.** Any overpayments will be refunded automatically to you.
- We accept cashier's check , American Express, Discover, Visa, MasterCard, and Carecredit for payment in full 3 business days before the patient is treated. You can apply for Carecredit at www.carecredit.com

• I understand that my health plan (Tricare and other plans) may impose a limit on balance billing by out of network providers. I wish to waive any limit on balance billing and receive treatment from this out of network provider.
• I understand that I am seeking the care of PDAA for a service that may not be covered by my insurance company. I understand that my insurance plan may not cover any part of the charges, costs or expenses related to Anesthesia services and I will be responsible for all charges incurred.

Parent Name:
Date: April 24, 2024

Medical History -

Gender:
○Male○Female

Age:

Date of Birth:
Select Date

Parent's Name:

Child's height (if known):

Child's weight: **lbs**

Home #:

Work #:

Cell #:

Dentist:

Does your child take any medications?	○Yes ○No	Please list all medications your child is taking
Does anyone smoke in your child's home?	○Yes ○No	
Allergies	○Yes ○No	If yes, please comment
Recent cold, cough or reactive airway	○Yes ○No	If yes, please comment
Snoring, asthma or breathing problems	○Yes ○No	If yes, please comment
Heart trouble, murmur, or heart surgery	○Yes ○No	If yes, please comment
Surgery or hospitalizations	○Yes ○No	If yes, please comment
Problems or complications with anesthesia	○Yes ○No	If yes, please comment
Cerebral palsy, Epilepsy, Seizures or Fainting	○Yes ○No	If yes, please comment
Developmental delay, Autism or ADHD	○Yes ○No	If yes, please comment
Any other medical conditions?	○Yes ○No	If yes, please comment
I have received the IV Sedation Information papers.	○Yes○No	

Today's Date April 24, 2024

Parent Name:

X

Signature Certificate

Document name: Medical Hx

Unique Document ID: 0DD602D000EA33BF3EF56A041B5B56ACD1924DE8

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