ADVANCED SPECIALTY ANESTHESIA, LLC

REQUEST FOR ANESTHESIA SERVICES

Patient Information

First Name M.I. Last Name

Home Address Apt. # City State Zip

Home Phone Cell Phone Work Phone Alternate Phone

Date of Birth: ____/____/____ Age: _____ Sex: M F Nickname: _____ Preferred Language_____

Parent/Guardian Information (patients 18 years of age or younger)

First Name M.I. Last Name Relationship to Patient

Home Address (if different from patient) Apt. # City State Zip

Cell Phone Number Email Address

Patient reside in a facility/nursing home? Please list name and phone _____

Health Insurance Information

Insurance Company: _____
Policy Number: _____ Group Number: _____
Phone Number (for Providers – located on back of card): _____
Policy Holder's Name: _____ Date of Birth: _____
Policy Holder's SSN: _____
Name of Employer or Company that provides benefits: _____

_____ I give permission for Advanced Specialty Anesthesia, LLC, to leave a message regarding information relevant to anesthesia services.
Patient/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY Referring Physician Office

Office Requesting Services: _____ Requested Appointment Date: ____/____/____

Reason for the Procedure:

- ☐ Dental Carries
- ☐ Accident/Injury Related
- ☐ (other)_____

Estimated Treatment Time:

- ☐ 1 hour
- ☐ 2 hour
- ☐ 2 hour 30 min
- ☐ (other) _____

_____ Copy of Proposed Treatment Plans (including procedure codes)
_____ Patient Medical History Form & Medical Insurance Card
_____ ASA Patient Authorization Health Information Release Form

ASA FAX: 785-422-5477

www.asasleep.com

Advanced Specialty Anesthesia, LLC

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____

Patient/Parent/Guardian Name (print please)

give permission to the following medical doctors/specialists to release the requested protected health information to Advanced Specialty Anesthesia, LLC

In Regards To:

_____

Patient Name (print please) DOB

Primary Medical Doctor:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Other Medical Doctor/Specialist:	
Facility:	
Address:	
Telephone Number:	**Fax Number:**

Submit to: **Advanced Specialty Anesthesia, LLC**
1201 Wakarusa Drive, Suite A-3
Lawrence, Kansas 66049
Phone: (785) 856-6170
Fax: (785) 856-6171

☑ **History and Physical**

☑ **Medication List**

☑ **Laboratory Results**

_____

Patient/Parent/Guardian Signature Date

_____

Primary Telephone # Cell # Work #

JOHN FASBINDER, D.D.S.
SETH COHEN, D.D.S.

SPECIAL CONSENT TO OPERATE OR OTHER PROCEDURE

PATIENT:_____ AGE:_____

1. I hereby authorize Dr. John Fasbinder Dr. Cohen and/or such associates and assistants as he may select, including but not limited to Advanced Specialty Anesthesia, to perform the following procedures:

_____

_____

_____

as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

2. I have been informed and understand that the procedures to be performed are necessary to treat or to further diagnose oral ill health conditions such as tooth decay, periodontal disease, and oral cancer.

3. I consent to the administration of such anesthesia as may be considered necessary or advisable by the doctor or his associates for this procedure or operation.

4. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates may consider necessary or advisable during the course of the operation or procedure. I further request, authorize and direct him to do whatever he deems advisable in the exercise of his professional judgment.

5. I have been completely informed as to, and understand, the nature and purpose of the operational procedures, the probable consequences thereof, the possible alternative methods of treatment as well as the possible risks and consequences of non-treatment. I have also been informed that there are general risks and hazards involved in surgical procedures, including severe loss of blood, infection, cardiac arrest, etc. Other risks, hazards and consequences involved in this operation or procedure include, but are not limited to, the following: infection, numbness (which could be permanent), jaw fracture, teeth/root displacements, aspiration and risk of anesthesia.

6. I acknowledge that no guarantee or assurance has been made to me concerning the results of the operation or procedure.

I CERTIFY THAT I HAVE READ (OR THIS HAS BEEN READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT TO PROCEDURE(S) ; THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETIONS WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE CONSENT IS SIGNED.

DATE:_____ _____

Patient, Guardian or Trustee

Updated: 3/22/17