Dental Anesthesia Services
Of Louisiana

Patient Registration

Please fill out this registration sheet and fax to our office at the time of preop consultation. Fax #: 318-759-0821

Today's date: __________________________ Height: _____________________ Weight: ___________________

Dentist: ____

Appointment date: ___________________Time: ______________Approximate length of procedure: _______

Patient's Name: ____DOB: ___________________________Sex_____

Parent/Guardian: ____

Patient's home number: _____________________________________ Cell: ________________________________

Medical History: *Parent/Guardian to complete*

1. List all medications your child is currently taking or have taken recently. Be sure to include all over-the-counter drugs.

Medications	Date/Time of last dose	Medications	Date/Time of last dose

List any previous surgeries or procedures in which your child has had anesthesia. List any problems Your child experienced as a result of anesthesia.

Previous Surgery / Year	Reaction	Previous Surgery / Year	Reaction

2. List any allergies to food, drugs, or latex ____

3. Does YOUR CHILD have a history of any of the following? If "yes" please explain.

Yes No Any family with a reaction to anesthesia? ____
Yes No Stroke, Seizures, other neurologic problem? _______________________________________
Yes No High blood pressure, heart failure, chest pain, irregular heart beat? __________________
Yes No Asthma, TB, sleep apnea, recent cold or cough? _____________________________________
Yes No Hepatitis, bleeding problems, liver problems? ______________________________________
Yes No Hiatal hernia, ulcers, frequent heart burn? ____
Yes No Diabetes or low blood sugar? ____
Yes No Problems with kidneys? ____
Yes No Other medical history? ____

I understand that if my appointment is not cancelled at least 2 business days in advance of my appointment date, if there is a violation of the fasting guidelines, or if I arrive more than 15 minutes after my scheduled appointment time that I will be rescheduled and charged the minimum 1 hour anesthesia charge.

Parent signature: ____Date: ______________________________