Anesthesia Questionnaire/Application

To ensure that the policyholder meets eligibility in the DBIC insurance program concerning the administration of Deep Conscious Sedation, Minimal Conscious Sedation, Nitrous Oxide Conscious Sedation, Central Nervous System Anesthesia or General Anesthesia. Please complete the following questionnaire and return to our office by ___________________________ (15 days).

Definitions:

General Anesthesia means an induced controlled state of unconsciousness in which the patient experiences complete loss of protective reflexes, as evidenced by the inability to independently maintain an airway, the inability to respond purposefully to physical stimulation or the inability to respond purposefully to verbal command.

Deep Conscious Sedation means an induced controlled state of depressed consciousness in which the patient experiences a partial loss of protective reflexes, as evidenced by the inability to respond purposefully either to physical stimulation or to verbal command but the patient retains the ability to independently and continuously maintain an airway.

Minimal Conscious Sedation means an induced controlled state of depressed consciousness, produced through the administration of nitrous oxide and oxygen in conjunction with the administration of a single agent oral sedative, in which the
patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

Nitrous Oxide Sedation means an induced controlled state of minimally depressed consciousness, produced solely by the inhalation of a combination of nitrous oxide and oxygen, in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

Central Nervous System Anesthesia means an induced controlled state of unconsciousness or depressed consciousness produced by a pharmacological method.

Permits:

1. Do you hold an active Anesthesia Permit(s)? Yes _____ No_____
2. What permit(s) do you hold? ____
3. Are there any restrictions to your Anesthesia Permit(s)? Yes _____ No_____

If yes, please explain: ____

____

If restricted, are you eligible for reinstatement? Yes _____ No_____
Date eligible for reinstatement:____________________

Specialty Procedures:

1. Do you hold a Dental License or Certification to perform procedures as an Oral Surgeon?
   Yes____ No_____

2. Do you receive patient referrals from other provider's to perform procedures involving Oral Surgery?
   Yes____ No_____

3. Is your dental office advertised as a specialty practice? (e.g. cosmetic, implants, etc.)
   Yes____ No_____
4. If yes, please specify ______________________ and provide a copy of your current advertisement or brochure.

Minimal or Deep Conscious Sedation, or General Anesthesia:

What type of anesthesia/analgesia is administered when treating patients under minimal or deep conscious sedation?

1. Inhalation:______________Nitrous Oxide: (when used in combination with other anesthetic or analgesic agents) _______________Other:__________________________

2. Intravenous:____

3. Intramuscular (including submucosal)__________________________

4. Combination:____

5. Where are conscious sedation and general anesthesia procedures performed?
   Office Only_______ Hospital Only______________ Office and Hospital________

6. List all sedatives used in your dental practice:

   __________________ __________________ __________________

   __________________ __________________ __________________

   __________________ __________________ __________________

Facilities & Equipment:

When minimal or deep conscious sedation is administered in the dental office do you have the following facilities, equipment and drugs available during the procedures and during recovery?

1. An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and room to allow an operating team of at least two individuals to freely move about the patient; Yes____ No_____

2. An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support; Yes____ No_____

3. A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure; Yes____ No_____

4. Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure; Yes____ No_____

5. An oxygen delivery system with adequate full-face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system; Yes____ No_____

6. A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system; Yes____ No_____

7. A recovery area that has available oxygen, adequate lighting, suction and electrical outlets; Yes____ No_____

8. Sphygmomanometer, precordial/pretracheal stethoscope or capnograph, pulse oximeter, electrocardigraph monitor, defibrillator, laryngoscope with endotracheal tubes, oral and nasopharyngeal airways, intravenous fluid administration equipment; Yes____ No_____

9. Emergency drugs including, but not limited to: pharmacological antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistamines, antiarrhythmisc, antihypertensives and anticonvulsants; Yes____ No_____

10. When was the last time the Equipment and Emergency Medical Equipment pertaining to the use, monitoring and administration of anesthesia and emergency resuscitation evaluated for safety and or adjustment?

    Date:_____________ By whom:_________________ Company:_________________________________

    Address, city, state, zip:________________________________ Phone:_____________________

    Please enclose a copy of the most recent certification as to the condition and workmanship of the equipment. If not completed within the past two years, you will need to schedule an equipment maintenance evaluation, at your own expense, to ensure that the equipment is properly functioning and calibrated as required by the Manufacturer or the State Medical Board.

Anesthesia Administration:

1. Who do you employ or utilize for the administration of anesthesia?

Anesthesiologist (MD)_______________ Dentist Anesthesiologist____________________________

Other (specify)______________________

2. Who is responsible for determination of the dosage and type of anesthetic?

____

3. What Certification does the person responsible for the administration of anesthesia hold?

____

4. If you use the services of a qualified anesthesia provider in your dental office, do you provide written notice to the State Board of Dental Examiners? Yes____ No_____

5. If utilizing the services of a private contractor (RN, CRNA, Dental Anesthetist, MD, etc.), do you require proof of liability insurance naming you as Additional Insured under their liability policy? Yes___ No____

Attach proof of Anesthesia Certification and proof of Liability coverage or complete the following information: Insurer_________________________________ Policy No.:_________________
Named insured:___________________________________ Dates of coverage:____________
Limits of liability:_________________________________

Prior to administering anesthesia do you:

1. Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or conscious sedation? Yes____ No_____

2. Obtain written informed consent from the patient or patient's guardian for the anesthesia? Yes____ No_____

3. Provide to the patient/guardian complete procedures, alternative treatment available, risks associated with treatment and answer all questions? Yes____ No_____

4. Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian or responsible third party to whom patient is released following conscious sedation or general anesthesia?
   Yes____ No_____
5. Do standard instructions include written caution for the operation of a motor vehicle or machinery, pre and post operative? Yes____ No_____

Assistant:

1. Does the assistant hold the proper licensure as required by the State Dental/Medical Board for any treatment provided under your direct supervision, including, but not limited to the introduction of anesthetic agents? Yes____ No_____

2. Is the assistant trained and competent in dealing with medical emergencies, monitoring vital signs and the use of the electrocardiograph monitor, sphygmomanometer, precordial/pretracheal stethoscope, capnograph, and pulse oximeter? Yes____ No_____

3. After adequate training, does an assistant, when directed by you, the dentist, introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist?
   Yes____ No_____

Monitor:

1. Who is the person designated in your dental practice as the monitor for patients who are under general anesthesia, deep conscious sedation, minimal conscious sedation, or nitrous oxide conscious sedation? Check all that apply.

   Dentist _______ Dental Assistant _______
   Anesthesiologist (MD) _______ Other(please specify) ______________
   CRNA _______

2. Please provide valid and current certification of all that apply: BLS/CPR, ACLS, PALS and

   a. Completion of a comprehensive training program in parenteral conscious sedation, anesthesia and related subjects that satisfies the requirements described in Part II & III of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry; or

   b. Completion of an ADA accredited postdoctoral training program (e.g., general practice residency), which affords comprehensive and appropriate training necessary to administer and manage general anesthesia or parenteral conscious sedation.

Please provide proof of Certification for all parties to be considered for coverage or renewal under the DBIC Insurance Program.

Patient Monitoring:

1. Do you monitor and record the patient's condition or use an assistant qualified as a monitor to monitor and record the patient's condition? Self___ Assistant_____

2. Do patients have continuous monitoring using pulse oximetry?
Yes____ No_____

3. Is the patient's blood pressure, heart rate, oxygen saturation levels and respiration recorded every 15 minutes, and are these recordings documented in the patient record including time of recording?
Yes____ No_____

4. Do you record and include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration?
Yes____ No_____

5. While a patient is under minimal or deep conscious sedation, is he/she continuously monitored?
Yes____ No_____

6. During the recovery phase, is the patient monitored by an individual trained to monitor patients recovering from conscious sedation? Yes____ No_____

7. Is the patient recovery period aligned with the standards established by the State Board?
Yes____ No_____

Patient Discharge:

Do you, the dentist, assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met?
Yes____ No_____

1. Vital signs including blood pressure, pulse rate and respiratory rate are stable

2. The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status

3. The patient can talk and respond coherently to verbal questioning

4. The patient can sit up unaided

5. The patient can ambulate without assistance

6. The patient does not have uncontrollable nausea or vomiting and has no signs of dizziness.

7. Do you or your office staff release a patient who has undergone deep conscious sedation without the care of a responsible third party? Yes____ No_____

   If yes, in what circumstances?____

8. Is a discharge entry made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged?
Yes____ No_____

Procedure History:

Please specify the types of major and minor procedures performed while treating patients under any form of conscious sedation. Please include the percentage of practice time in which these procedures are performed on a monthly basis. Attach a separate sheet for additional procedures or comments.

Major: type___________________________(%)_____ type: _______________________________(%)_____

type___________________________(%)_____ type: _______________________________(%)_____

type___________________________(%)_____ type: _______________________________(%)_____

Minor: type___________________________(%)_____ type: _______________________________(%)_____

type___________________________(%)_____ type: _______________________________(%)_____

type___________________________(%)_____ type: _______________________________(%)_____

Education:

Do you hold current certification showing successful completion of a Health Care Provider BLS/CPR, ACLS or PALS and participate in continuing education in one or more of the following areas every two years?

- ❑ Sedation Yes____ No ____ # of hours_____________
- ❑ General Anesthesia Yes____ No_____ # of hours_____________
- ❑ Physical evaluation Yes____ No ____ # of hours_____________
- ❑ Medical emergencies Yes____ No ____ # of hours_____________
- ❑ Monitoring and the use of monitoring equipment Yes ___ N_________# of hours_____________
- ❑ Pharmacology of drugs and agents used in sedation Yes ____ N________ # of hours___________
- ❑ Health Care Provider Basic Life Support (BLS) or Cardio Pulmonary Resuscitation (CPR) or Advanced Cardiac Life Support (ACLS) or Pediatric Advance Life Support (PALS)
  Yes____ No_____ # of hours_____________

Please attach proof of Course Completion.

I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement could invalidate my coverage.

I further understand that this questionnaire/application, if approved, will become and forms a regular part of my insurance policy underwritten by Dentists Benefits Insurance Company.

Print Full Name:_____________________________________

Signature in Full:____________________________________ Date: _______________________