Martin R. Boorin, DMD
David Pfeffer, DDS

Anesthesia For Dental Health

Dear Parent:

Your pediatric dentist or surgeon has recommended our anesthesia services for your child's dental or surgical care. Our mission is to provide the highest standard of patient care and safety, in the comfort, convenience and familiar surroundings of the office of your child's dentist or surgeon. Anesthetic medications will allow your child to "sleep" through the procedure in a safe, controlled, and monitored setting thus allowing your child's dentist or surgeon to provide the highest quality, comprehensive and pain-free treatment. Most children report no memory of receiving their dental / surgical treatment. Children routinely return to their usual activities by the next day.

Please review, sign, and Email, FAX or Mail the forms below to our office as soon as possible.

Text

- **Pediatric Medical Questionnaire**
- **Financial Agreement**
- **Insurance Data Sheet**
- **Preoperative / Postoperative Instructions**
- **Consent for Healthcare Information Disclosure**
- **Copy of Medical Insurance Card [Front and Back]**

Preparation is Very Important: Several weeks prior to your appointment, our office staff will personally contact you. They will review your child's health history, explain the anesthesia plan in careful detail, and answer any questions that you might have concerning your child's anesthesia care. We routinely contact parents when medical questions arise, as well as on the evening prior to the day of treatment.

Deposit:

We require a **deposit of $ 500** when your child is scheduled for treatment. **Failure to submit a deposit may lead to rescheduling your child to a future treatment date**. **This deposit is non-refundable except for illness or cancellation greater than two weeks prior to the scheduled appointment.**

Medical Evaluation by your Pediatrician:

You must schedule a preanesthetic evaluation with your child's pediatrician. This visit should be **scheduled 1 week prior to the scheduled date of treatment.** ***Please have the attached Medical Evaluation form or your pediatrician's form completed and returned by FAX or secure email to us.*** In addition, please bring the original, completed form to the office on the day of the procedure.

On the day of treatment:

- Your child **must not** have any food for 8 hours, nor any clear liquid for 2 hours prior to the appointment.
- Have your child wear loose, comfortable pants, a short-sleeved shirt (and a sweat shirt in winter).
- Please place a diaper or pull-up on your child, if appropriate.
- Bring a warm blanket (everyone gets cold during an anesthetic).
- *Bring **ALL** forms that both you and your pediatrician were required to complete.*
- *We strongly suggest two adults accompany your child home.*

Following an examination and discussion with you, we will administer a sedative to your child while you are present. This may not be required for older, adolescent children. After the sedative has taken effect, your child will be transferred to the treatment area (older children may receive a sedative in the treatment room while you are present). We will administer oxygen and monitor your child's heart rate, blood pressure, oxygen saturation, respiration, and body temperature. An intravenous line will be started and medications will be given as needed to keep your child comfortable, pain free, and asleep throughout the entire dental procedure. Accompanying adults (parents/guardians) will remain in the reception area during the entire treatment. This is to ensure that the doctors are able to completely focus their attention on your child, thereby ensuring maximum safety.

If you are unsure of anything or have additional questions, do not hesitate to call Merle, our office manager, at (631) 940-3690. We are also available on a daily basis to answer questions or concerns. We look forward to assisting you toward completion of your child's dental treatment or surgery with the highest quality of care and safety in the near future.

Sincerely,

Martin R. Boorin, DMD — Martin R. Boorin, D.M.D.

David Pfeffer, DDS — David Pfeffer, D.D.S.

Web Site: anesthesiafordentalhealth.com **Email Address:** anesthesia.dentalhealth@gmail.com

P.O. Box 107 Huntington Station, NY 11746 Office: (631) 940-3690 Fax: (631) 239-8405

Martin R Boorin, DMD
David Pfeffer, DDS

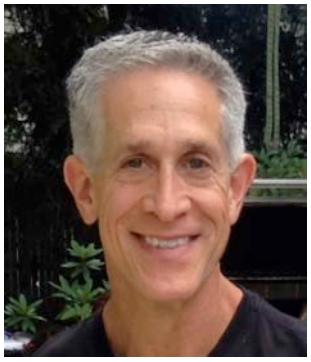
Anesthesia For Dental Health

ANESTHESIA SERVICES for CHILDREN'S DENTAL CARE

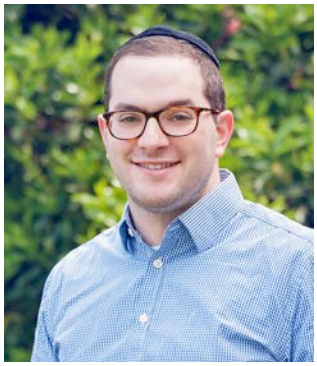
All parents want their children to receive the best comprehensive dental treatment possible. Even a skilled pediatric dentist may occasionally have limited success completing dental treatment for a fearful or pre-cooperative child as well as for a child with special needs. Younger children typically experience a degree of stranger anxiety, a short attention span, and a limited tolerance for keeping their mouth open. The complexity and magnitude of the dental treatment may also reduce the success of behavior management or non-medication strategies by the dental team. Subsequent delays in receiving proper dental care can lead to oral pain, infections, loss of teeth and loss of space for future eruption of permanent teeth

Anesthesia services are available to complete your child's dental treatment in these circumstances. A qualified anesthesiologist who uses mediations and monitors equal to those currently used in hospitals can provide this care. Children are often given a sedative prior to receiving their inhalation or intravenous anesthetic. Each child receives an individually prepared and titrated anesthetic with close and continuous monitoring of heart rate, blood pressure, respiration, and patient awareness. They remain in a general anesthetic state with profound amnesia and pain control throughout their dental treatment. This enables the treating dentist to efficiently and safely complete all planned dental or surgical treatment in the shortest amount of time. Most children are ready to return home soon after the completion of their dental treatment.

ANESTHESIOLOGY STAFF



Martin R. Boorin, DMD is an experienced, residency-trained, fully qualified dentist anesthesiologist. He is a graduate of the University of Connecticut, School of Dental Medicine and completed his two-year anesthesiology residency at Long Island Jewish Medical Center. Dr. Boorin has been in the practice of dental anesthesiology for over 30 years, including a full-time hospital anesthesia practice for thirteen years, and has been a staff dentist anesthesiologist at Long Island Jewish Medical Center since completing his residency in 1987. He currently maintains a full-time, office-based practice of dental anesthesiology in the tri-state region for pediatric, adult, and special needs patients. Dr. Boorin is a clinical assistant professor, in the Departments of Hospital Dentistry and Dental Anesthesiology at the Stony Brook School of Dental Medicine and an attending dentist anesthesiologist at Stony Brook University Hospital. He is the section chief for dental anesthesiology in the Department of Dental Medicine at Long Island Jewish Medical Center. Dr. Boorin coordinates resident education and clinical care in both institutions and is one of several attendings supervising an accredited, nationally recognized dental anesthesiology resident training program. Dr. Boorin is a diplomate of the American Dental Board of Anesthesia and has served on the ADBA Board of Directors. He is active in and lectured before numerous local and national professional organizations. When not working professionally Dr. Boorin enjoys time with his family, cooking, travel, and is an avid cyclist.



David Pfeffer, DDS is a residency-trained, experienced dentist anesthesiologist, trained in the administration of sedation and general anesthesia in hospitals, ambulatory centers and private offices. He attended the University of Maryland School of Dentistry. Subsequently he completed a three-year General Practice Residency Medical Track and Dental Anesthesiology Residency at Stony Brook University Hospital, a level-one trauma center. In addition to practicing anesthesia, Dr. Pfeffer is a clinical assistant professor in the Departments of Hospital Dentistry and Dental Anesthesiology at the Stony Brook School of Dental Medicine where he works with dental residents in treating adults with special needs in Southampton Hospital. He has lectured to health care providers locally and regionally, as well as during national meetings. When not caring for his patients, Dr. Pfeffer enjoys spending time with his family, jogging, and cooking

Martin R. Boorin, DMD, PC
David Pfeffer, DDS

Anesthesia For Dental Health

Pediatric Medical History Questionnaire

P.O. Box 107
Huntington Station, NY 11746
Fax: (631) 239-8405

Parents, please take time to carefully fill out this questionnaire.
Please use the back of this form for additional comments.

Patient Name: _____ **Date of Birth:** _____/_____/____ **Age:** _____ **Weight:** _____lb

Address: _____ **City:** _____ **State**: _____ **Zip:** _____

Parent's Names: _____ **Home:** ( ) _____ **Cell:** ( ) _____

Treatment Date: __/__/__ **Dentist/Surgeon:** _____ **EMAIL:** _____

Medications: List all currently being taken by your child (**include vitamins, herbs, over-the-counter pills**): _____
_____

Allergies: Does your child have **allergies to any medications or foods**? If yes, list and state what happened? _____
_____

1. Is your child in good health? _____ Yes No
2. Was your child born **premature**? (if yes, born at _____ weeks) Where there Complications? _____
   Did your child have a breathing tube? If yes, for how long? (_____Days) _____ Yes No
3. Is your child currently or regularly under the care of a physician _____ Yes No
4. Has your child had any serious illnesses, accidents, operations, or been hospitalized? _____ Yes No
   Please Explain (**Continue on back if needed**)**:** _____
5. Does your child have or has he/she had in the past any of the following heart diseases or complications? _____ Yes No
   Circle all that apply: Congenital heart defects, Heart Murmurs, Malfunctioning heart valves, Pacemaker, Irregular heart beats, Ventricular or Atrial Septal defects?
6. Does your child have or has he/she had in the past any of the following Heart complications? _____ Yes No
   Circle all that apply: Chest pain, Cyanosis, or Shortness of breath on exertion, High Blood Pressure, Stroke
7. Has your child had a **recent nose, throat, chest cold or flu**? _____ Yes No
   How long has it been fully resolved? _____ (days / weeks)
   Are there continued symptoms (example, cough, fever, home from school, nasal discharge)? _____ Yes No
8. Does your child have or has he/she had in the past any of the following lung diseases or complications? _____ Yes No
   Circle all that apply: Bronchitis, Pneumonia, Chronic cough, Chronic sinus disease, Seasonal allergies
9. Has your child ever had **Asthma**? _____ Yes No
   When was the last attack? _____ (weeks / months / years)
   How severe and how often do the attacks occur? _____
   Does your child need daily asthma medication or do you just use medication as needed? _____ Every day As needed
   Have steroid medications ever been used? If so, how often? _____ Last use? _____
10. Does your child have **Tonsil or Adenoid** problems? _____ Yes No Is your child a **Mouth Breather**?____ Yes No
11. Has your child been diagnosed with **Sleep Apnea** or is there loud snoring **<u>every night</u>** when sleeping? _____ Yes No
12. Is your child exposed to **Second-hand smoke**? _____ Yes No
13. Does your child have or has he/she had in the past any of the following diseases or complications? _____ Yes No
    Liver (Hepatitis, jaundice)? _____ Yes No
    Kidney (Kidney stones, Ureter or Bladder disorders, Renal insufficiency or failure)? _____ Yes No
    Thyroid Disease or Diabetes?_____ Yes No
    Stomach Problems (ulcers, excess stomach acid, or reflux, persistent diarrhea, weight loss)? _____ Yes No
    Arthritis (swollen or painful joints or lymph nodes)? _____ Yes No
    Muscle disorders or weakness (Low muscle tone, muscular dystrophy)? _____ Yes No
    Seizures, Fainting Spells, Frequent Headaches, or other neurological problems? _____ Yes No
    Intellectual Disabilities, Depression, ADHD, Autism, PDD, or any other problems with mental health? ____ Yes No
    Cancer, Sexually transmitted diseases, HIV, AIDS? _____ Yes No
14. Does your child bruise easily or has he/she ever been diagnosed with a bleeding disorder? _____ Yes No
15. Does your child have any blood disorders such as Anemia or Sickle Cell Anemia? _____ Yes No
16. Has any blood relative of the patient ever had a bad or unusual reaction to anesthesia? _____ Yes No
17. Does your child have any disease, disorder, or complication not mentioned above? _____ Yes No
    If yes, please explain: _____

Additional Comments: (**Continue on back if needed**) _____

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Drs. Boorin and Pfeffer to discuss my child's medical health with other health professionals involved with my child's care..

Parent / Guardian Signature: _____ **Printed Name:** _____ **Date:** ___/___/___

Financial Agreement & Insurance Information

Martin R. Boorin, DMD, PC
David Pfeffer, DDS

Anesthesia For Dental Health

Everyone benefits when financial arrangements are agreed upon in advance. This material will acquaint you with our financial policies regarding payment of anesthesia services and submission of insurance claims.

Patient's Name: _____ **Date of Procedure** ____/____/____

Dentist / Surgeon's Name: _____

Anesthesia Fee Estimation:

Dentist / Surgeon's ESTIMATED dental treatment time	_____ Min
Estimated anesthesia time [dental treatment time **plus preop / postop time (additional 45 minutes)**	_____ Min
Initial 60 Minutes	$ 1125.00
Additional Time ($ 125 x _____)	$ _____
Total Estimated Anesthesia Fee	$ _____
Less the Deposit	$ 500.00
ESTIMATED TOTAL DUE ON THE DAY OF SURGERY	$

Anesthesia fees are based on units of time:
$ 1125 for the first 60 minutes of anesthesia
$ 125 for each additional 15-minute increment of anesthesia
(The anticipated Minimum Charge for anesthesia is $ 1125)

PAYMENT FOR ANESTHESIA SERVICES IS DUE IN FULL ON THE DAY SERVICES ARE PROVIDED:
I, *the Parent/Guardian*, acknowledge full financial responsibility for the payment of anesthesia services. I understand that by signing this document, I am agreeing to pay Drs. Boorin or Pfeffer their full fee for anesthesia services on the day of services rendered. If the anesthesia time exceeds the estimate, the patient/parent/guardian will be responsible for the additional fee. If the anesthesia fee is less than the estimated time, the patient/parent/guardian with be charged based on the actual anesthesia time. I understand that payment for anesthesia services may be made by: Cash, Bank Check / Money Order, or Credit Card (Visa / MC / Discover, A/E).

DEPOSIT POLICY:
It takes great effort, time, and coordination between the offices of the dentist and dentist anesthesiologist to schedule your appointment. **A Deposit of $ 500.00 is therefore required at the time the treatment visit is scheduled. Your $500.00 deposit is NON-REFUNDABLE with the exception of the onset of illness or cancellation greater than 14 days in advance of the scheduled treatment date**. Failure to comply with instructions relating to eating and drinking, or a minimum 14 day advanced cancellation notice will result in cancellation of the appointment and forfeiture of your deposit. This financial agreement, along with the deposit, must be signed and returned to the address below or the treating dentist's office prior to the anesthesia appointment. Deposits may be received by one of the following methods; Cash, Bank Check, Money order, or Credit Card (please complete form below).

INSURANCE: As a Courtesy, We Will Submit to Your Medical Insurance Carrier on Your Behalf and Require Completion of an Insurance Data Form and Your Medical Insurance Card

It is important that reimbursement for the anesthesia fee by dental or medical insurance programs NOT be assumed. Many insurance policies DO NOT pay for anesthesia services for dentistry or have limitations on individual policies. We are an out of network provider. You must contact and check with your Dental or Medical Insurance Company representatives to discuss your specific benefits. You will receive a detailed "Anesthesia Statement of Services Form" at the conclusion of the anesthesia procedure. An insurance company is more likely to accept a claim when the patient has a documented need for anesthesia services. These may include, but are not limited to the following: ***history of failed local anesthesia, allergies to local anesthetics, cerebral palsy and heart/lung diseases***. A note from your physician acknowledging the need for anesthesia services will be helpful.

I have read, agree, and received a copy of the financial agreement and deposit policy.

Signature: _____ **Print Name:** _____ **Date:** _____

Credit Card (circle): MC Visa Discover **Card # :** _____ **Exp. Date:** _____

Deposit Amount: $ _____ **Security Code [Back of Card, 3 digits for MC, Visa, 4 digits for AE]** _____ **[Required]**
The Cardholder acknowledges responsibility for payment of the non-refundable deposit and agrees to perform the obligations set forth in the cardholder's agreement with the issuer.
Cardholder Signature: _____ **Cardholder Name:** _____ **Date:** _____
Cardholder Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Office use: **Deposit Payment:** **Cash** **Check / Money Order [# _____]** **Credit Card**
Amount of Deposit Received: $ _____ Received by: _____ **Date:** _____

P.O. Box 107 Huntington Station, NY 11746 Office: (631) 940-3690 Fax: (631) 239-8405

Martin R. Boorin, DMD, PC
David Pfeffer, DDS

Anesthesia For Dental Health

CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your child's/dependent's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your child's/dependent's protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We will provide you a copy to read prior to signing this Consent at your request. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's/dependent's protected health information that we maintain.

Right to Revoke:

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed in the Notice of Privacy Practices. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat or continue to treat your child/dependent if you revoke this Consent.

❑ **Consent Given**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure my child's/dependent's protected health information to carry out treatment, payment activities and health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters/information pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters/information. I further understand that I may revoke this Consent in the future if I should so desire.

I further understand that I have the right to review the Notice of Privacy Practices of Martin R. Boorin, DMD, PC and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

❑ **Revocation of Consent**

I hereby revoke my Consent for your use and disclosure of my or my child's/dependent's protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took, in reliance on my Consent before you received this Notice of Revocation. I also understand that you may decline to treat or to continue to treat my child/dependent after I have revoked my Consent

_____ _____ _____

Print Name Signature Date

Patient Name _____ Patient Date of Birth: _____

Martin R. Boorin, DMD, PC
David Pfeffer, DDS

Anesthesia For Dental Health

Insurance Reimbursement

We are offering to submit medical insurance forms on your behalf to enable you to receive reimbursement from your insurance company(s). We require the following information to efficiently and successfully submit a claim to your insurance company for your reimbursement:

Insurance data sheet [See Below] **AND** **Medical insurance card copy [Front and Back]**

Your dentist / surgeon will provide us with a **treatment summary** and a **letter of necessity**, which will be included in the insurance submission.

Patient Insurance Information

Patient Name: _____ **Date of Birth:** _____

Insurance Carrier:

Name: _____

Address: _____

Telephone #: _____

Employer: **Name:** _____

Address: _____

Telephone #: _____

Policy Holder Name: _____ **Date of Birth:** _____

Social Security #: _____

Insurance ID #: _____ **Group #:** _____

Is there Secondary Insurance? **YES** **NO**

Secondary Insurance Carrier:

Name: _____

Address: _____

Telephone #: _____

Employer: **Name:** _____

Address: _____

Employer Telephone #: _____

Policy Holder Name: _____ **Date of Birth:** _____

Social Security #: _____

Insurance ID #: _____ **Group #:** _____

Martin R. Boorin, DMD
David Pfeffer, DDS

Anesthesia For Dental Health

The Pre-anesthetic instructions herein must be strictly adhered to before undergoing anesthesia and will make the scheduled dental treatment under anesthesia safe and successful.

Neglecting any of the following instructions may compel the doctor to postpone the treatment.

The Anesthesia Deposit will be forfeit if children eat on the day of treatment unless we instruct you to do so.

PRE-ANESTHETIC INSTRUCTIONS

EATING AND DRINKING

Nothing to eat after midnight prior to your child's scheduled appointment unless otherwise instructed. Your Child is allowed moderate amounts of clear liquids (8 ounces) up to two (2) hours prior to the scheduled appointment. **CLEAR LIQUID = Water, Apple juice, Jello, Gatorade, Popsicles**
DO NOT GIVE: Milk, Soup, Non-clear or Pulp-containing juice

MEDICATIONS

Prescription medications should be taken as per their regular schedule, unless previously discussed and modified by Dr. Boorin or Dr. Pfeffer. **MEDICATIONS MUST ONLY BE TAKEN WITH A CLEAR LIQUID**. Vitamins, herbal products, and non-prescription medications **should not** be taken.

CHANGES IN HEALTH

A change in your child's health, especially the development of a cold or fever, is very important. Inform our office of any change in their health that occurs prior to your child's appointment. For their safety, we may need to reschedule for another day.

HOME PREPARATION

Make sure to give your child a good night's sleep before the day of the procedure. They should wear comfortable, loose fitting clothing. We suggest a short sleeve shirt, and a sweat shirt over it if needed. Contact lenses must be removed. A blanket and a change of clothing are suggested in case of accident.

ARRIVING

Arrive early enough to allow for a discussion of your child's health, a brief examination, consent for anesthesia and question answering.

GETTING HOME

Children will be sleepy after the procedure and must be accompanied by at least one parent if not two adults, one to drive and the other to attend to the child during the ride home. They must be seat belted in as they are less prepared to brace themselves during sudden stops. Do not take mass transportation (bus, train). Children may develop nausea on the ride home, be prepared.

HOME

A responsible adult should remain with the patient until the next day

POST-ANESTHETIC INSTRUCTIONS

ACTIVITY

After returning home, your child should rest for the remainder of the day and be observed. It is common for patients to be sleepy, dizzy or off-balance after receiving anesthetics. Children may return to school the next day if they have had an early to mid-day procedure and an uneventful night.

EATING AND DRINKING

Upon arrival home, the first drink should be one ounce of water or clear fruit juice every 15 minutes for 1.5 hours, followed by clear liquids and soft carbohydrate foods for an additional 1.5 hours. Give your child small drinks frequently, throughout the day. Hydration is more important than foods. Hold dairy and meats for at least 3 hours following your arrival home.

POST TREATMENT EFFECTS

Some common after-effects include sleepiness, dizziness, nausea, (may be worse after car ride home), soreness of mouth, jaws and throat, dry mouth, muscle aches and shivering. These symptoms may last for 1 to 3 hours, and on rare occasions somewhat longer. Children receiving treatment in the afternoon may be sleepier afterward due to coinciding nap times.

INTRAVENOUS SITE

A very small percentage of patients experience post-operative tenderness and/or redness in their hand or arm which may be a chemical phlebitis associated with intravenous infusion. If this occurs please contact Dr. Boorin or Dr. Pfeffer immediately. If phlebitis does occur the patient should receive an anti-inflammatory agent (acetaminophen or ibuprofen). Apply warm compresses, and elevate the arm.

SEEK ADVICE IF

Vomiting persists beyond four hours on four separate occasions. Unable to drink liquids 4 hours after arrival at home. Temperature elevates rapidly or remains elevated. Other matters cause concern.

PAIN MEDICATION

Expect to give your child Tylenol or Ibuprofen after the procedure to minimize any throat, mouth or tooth soreness. This should be started on arrival at home and repeated every 4 (Tylenol) or 6 (Ibuprofen) hour interval until the next day to ensure a good night's rest.

I have read, understand and agree to follow the above instructions **Date:** _____

Name: _____ **Signed:** _____

P.O. Box 107 Huntington Station, NY 11746 Office: (631) 940-3690 Fax: (631) 239-8405

Martin R. Boorin, DMD, PC
David Pfeffer, DDS

P.O. Box 107 ● Huntington Station, NY 11746
Office: (631) 940-3690

Anesthesia For Dental Health

Medical Evaluation prior to Dental Surgery with General Anesthesia

Please FAX completed Evaluation to (631) 239-8405
Please Return completed Evaluation to Parent to bring on day of treatment

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This pre-anesthetic HISTORY and PHYSICAL is to be completed by the patient's physician **one week prior to the date of the scheduled procedure**. Please return a legible and signed evaluation note addressing general health, prior significant or current systemic disease or illness as well as the patient's current functional status. If other clinicians need to be consulted, or if specific pre-anesthetic medications or lab tests are recommended, please specify. A comprehensive evaluation completed on your own office stationary or EMR is acceptable.

Patient Name: _____ **DOB:** _____ **Date of Treatment:** _____

Vital Signs: BP _____/_____ P _____ Temp _____ RR _____ Weight: _____ Height: _____

Summary History: _____
Medications: _____
Allergies: [ ] NKDA _____
Smoking / ETOH / Drugs: _____
Prior Surgery or Hospitalizations: _____
_____

PHYSICAL EXAM:

General Appearance: Well appearance [ ] _____
Head and Neck: WNL [ ] Tonsil/Adenoid Hypertrophy [ ] _____
Cardiovascular: WNL [ ] _____
[ ] Congenital Heart Disease [ ] CAD [ ] Valvular Heart Disease [ ] Arrhythmia [ ] PPM / AICD
Pulmonary: WNL [ ] _____
[ ] Recent URI [ ] Asthma [ ] COPD [ ] Sleep Apnea
Gastrointestinal: WNL [ ] _____
[ ] Reflux [ ] Hiatus Hernia [ ] Dysmotility [ ] Dysphagia
Renal: WNL [ ] _____
Hepatic: WNL [ ] _____
Endocrine: WNL [ ] _____
[ ] Thyroid [ ] Diabetes _____
Metabolic: WNL [ ] ___[ ] Obesity _____
Musculoskeletal: WNL [ ] _____
Neurological: WNL [ ] _____
[ ] Cerebral Palsy [ ] PDD [ ] ADD/ADHD [ ] Seizures [ ] Developmental Delay(s) [ ] Neuropathy
OB / GYN: WNL [ ] _____
Available Lab Data: (EKG, Blood [When appropriate] _____
Urine HCG Test [When appropriate] _____

COMMENTS / RECOMMENDATIONS:

_____
_____

Physician Name: _____ **Signature:** _____

Telephone: (_____) _____ **Date:** _____/_____/_____