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INSTRUCTIONS FOR DENTAL TREATMENT UNDER GENERAL ANESTHESIA

Patient Name: _____ Date of Surgery: ___/___/___ Time: _____

Please have the enclosed forms completed and return to our office within seven (7) days of the scheduled appointment or by ___/___/____. Missing or incomplete information will result in the need to re-schedule the appointment.

PLEASE READ ALL INFORMATION CAREFULLY

We have scheduled the patient for dental treatment under general anesthesia. He/she may not have anything to eat or drink after midnight the evening before surgery. To do otherwise could result in serious injury or death. If the patient eats or drinks the day of surgery (including peg tube feedings) we will need to reschedule the appointment. Please tell everyone who is directly involved with the patient's care of this requirement.

1. All paperwork and consents must be returned to our office seven (7) days prior to the scheduled appointment. All paperwork expires sixty (60) days from the date signed. If the original consent form is restricted for any reason, a parent or legal representative must be available on the day of the appointment or the appointment will be cancelled.
2. Please arrive on time for the appointment if you are more than thirty (30) minutes late the patient may not be seen that day. **Please be advised that the appointment time given is an arrival time.** We strive to see each patient on or close to the arrival time but the needs of our patients may require us to change start times. We apologize in advance for any inconvenience this may cause you and we appreciate your understanding in this matter.
3. For the comfort and sensitivity of all our patients, please do not bring food or drink into the waiting area.
4. Please bring a change of clothes in the event of unexpected nausea or bladder accidents. Please remove all nail polish, eye and face make-up.
5. Plan for a minimum of 2-3 hours for the completion of dental work and post-operative recovery. You must remain in the waiting area for the duration of the appointment in the event our staff needs to discuss treatment with you. **THE PATIENT MAY NOT BE LEFT ALONE IN THE SURGERY CENTER AT ANY TIME, FOR ANY REASON.**
6. Upon completion of treatment, the patient will be kept in a recovery room to help them wake up from the anesthesia and to prepare for the trip home. The recovery room nurse will notify you when the patient is ready to leave the clinic area. In order to minimize disruption in the treatment and recovery areas, **PLEASE** remain in the waiting area until the nurse or attending dentist notifies you.
7. You will be contacted to confirm the surgery appointment **24 hours** prior to the scheduled appointment. If you must cancel your appointment for any reason, please give 48 hours notice prior to canceling. While we understand that emergencies arise, please be advised that if you cancel an appointment without proper notice, or if you fail to present for care on the day you are scheduled, the patient will be moved to the end of our waiting list. We appreciate your understanding and cooperation on this matter.
8. You are responsible for arranging transportation to and from the dental appointment. Private automobile, taxi or an authorized medical transport vehicle are the only methods of transportation that are allowed. We are not able to discharge a patient to travel by SEPTA, bus or train.